State of Nevada
Division of Mental Health
And Developmental Services

2004 Biennial Report

Produced by
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Division Program Evaluation/Information Technology Manager

January, 2005

DIVISION ADMINISTRATOR,
CARLOS BRANDENBURG, PH.D.

DEPUTY ADMINISTRATOR
DEBBIE HOSSELKUS, LSW

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MHDS 2004 Biennial Report

The Division of MHDS provides a variety of inpatient and community based services to best meet the changing needs of Nevadans

This report provides a biennial summary of services and activities. Reports concerning strategic planning, medication, needs assessment and other topics can be accessed. For further information regarding the Division of MHDS and any of it's agencies, please visit our website at:

http://mhds.state.nv.us/

FROM THE ADMINISTRATOR

DIVISION ADMINISTRATOR, CARLOS BRANDENBURG, PH.D.

These are exciting times for the Division of Mental Health and Developmental Services.

In 2003 the report was released from the President's New Freedom Commission on Mental Health with recommendations to transform America's mental health system. Nevada capitalized on this historic event by passing Senate Bill 301 which developed the Nevada Mental Health Plan Implementation Commission. The task of the Commission was to develop an action plan in Nevada for implementing the recommendations of the President's Commission. Nevada is the only state to develop such a state committee charged with achieving these national goals.

An Executive Summary From The MHDS Administrator:

It is with great pleasure that I present to you our third Biennial Report. This is our Division's premiere report and is published every other January; designed to be made available with our most recent service related data in time for each session of the Nevada Legislature.

This report can give the reader a clear overview of the Division's programs, and an understanding of our challenges and accomplishments, as well as our major new plans for the next two years. You will also get to know the consumers we serve.

This report covers the past two years; (July 1, 2002-June 30, 2004), which is referred to as a "biennium", or the two-year period between each Nevada Legislative session. While a key audience for this report is our Legislators during the upcoming January-June 2005 session, we also provide this report to many other interested stakeholders.

⇒ Since our last biennial report in 2003, with the support of Governor Kenny Guinn and the 2003 Legislature, ***MHDS received 90 million additional state general fund dollars; an increase of 32.5%.*** Our mental health programs received an increase of 45 million (30.9% increase), while our Developmental Services programs received an increase of 42.8 million (33.7% increase). Currently, we devote almost 70% of our total budget to community-based services. Most of these increases addressed the tremendous population growth in Clark County. SNAMHS received a budget increase of almost 35% ($28 million) and 72 of the total 89 new positions. Desert Regional Center received a 33% increase ($24.5 million).

⇒ ***The single overarching challenge facing Nevada's system of public mental health today is the emergency room (ER) overcrowding in Clark County.*** The statistics show that, in spite of our efforts, this problem continues to grow. To illustrate, using annual averages, in 2003 we had 28 people waiting 45 hours to be admitted into our inpatient hospital at SNAMHS. In 2004, we had 42 people waiting 61 hours. So far in FY05, this trend has not slowed; with 62 people waiting 93 hours for admission. I remain increasingly concerned as these statistics continue to grow. With the support of Governor Guinn, the Interim Finance Committee approved a $3.5 million dollar supplement so that MHDS could open up 28 additional beds, raising the total acute care beds at SNAMHS from 77 to 105. This increasingly difficult situation was made much worse with the loss of 133 private psychiatric beds during 2000-4. Currently there are only 36 private psychiatric beds in Las Vegas Valley; this places more burden on the public mental health system that historically has been a safety net for the indigent and the uninsured. MHDS must now also provide services to people who have insurance, Medicaid, or Medicare coverage.

In addition to helping MHDS address Nevada's ER crisis, support from the 2003 Legislature also enabled MHDS to provide strengthened community-based mental health programs to assist those consumers who rely on our outpatient services. All MHDS programs work towards reducing the need for hospitalization and foster consumer recovery and resiliency in the community. Nevada will be building a new 150-bed psychiatric hospital. Located in Clark County, we plan to break ground in January 2005, with a projected completion date of June 2006. A key topic for the upcoming 2005 session will be staff planning and resources as the building itself is completed.

MHDS has started to address the shortage of acute beds and the overcrowding of the emergency rooms in Clark County through a wide array of critically needed programs…let me highlight some of these below.

⇒ **Mobile Crisis Team -** In September 2004, Nevada's first ever-Mobile Crisis Team was started in greater Las Vegas. The team is available, in greater Las Vegas, from 7:00a.m. to 10:00 p.m. seven days a week to evaluate individuals with mental illness in the Las Vegas Valley's emergency rooms and assist in triaging them to appropriate services.

⇒ **Programs for Assertive Community Treatment (P.A.C.T.)-** We added a second PACT team in Southern Nevada, so that we have three PACT teams statewide; one PACT team at NNAMHS, and two teams at SNAMHS. These PACT teams use an evidence-based approach to provide highly specialized services for over 200 people with the most serious mental illness residing in community settings. Substance abuse counselors were added to these programs to make our PACT programs as effective as possible with individuals who have co-occurring disorders. Empirical data shows that Nevada's P.A.C.T. programs have clearly met the goal of reducing hospital recidivism as well as improving the consumer's quality of life.

⇒ **New Management Information System (MIS) -** I'm proud that MHDS has received over 2.5 million in new dollars from the 2003 Legislature to design and implement a new integrated MIS; we refer to as "Avatar®". This new system is being implemented over three years, in phases. In Phase 1, as of July 2004, we completed the design and implemented the financial and pharmacy reporting modules. This means that Nevada now has, for the first time ever, standardized billing codes/procedures, which can be monitored centrally. This should result in MHDS collecting increased Medicaid and non-state revenues.

FROM THE ADMINISTRATOR

Over the next biennium, the Division of Mental Health and Developmental Services has many challenges. Included in these challenges is our commitment to the elimination of all seclusion and restraints in our inpatient facilities, addressing the service demand in the emergency rooms in Clark County, reducing the high suicide rate in Nevada, providing more community living alternatives, and addressing the high demand for services to people with developmental disabilities. Working in partnership with consumers, families, advocacy groups, agencies and communities the Division of Mental Health and Developmental Services will be able to meet these challenges and ensure responsive services and quality outcomes. Our mission of providing person-centered services in the least restrictive environments will be realized and consumers will have the opportunity to maximize their independence and self-sufficiency.

Vision

Our vision is to assist all Nevadans with mental illness or developmental disabilities to realize their optimal potential as individuals and as valued citizens of their community and state .

MHDS Strategic Plan Goal #1:

Develop and implement evidence-based treatment and interventions for adults and children.

Phase Two began on schedule in July, 2004, and introduced the use of electronic medical records for mental health agencies. Our staff will begin phasing in the use of these electronic records in March 2005, with the complete MIS implemented statewide by June 2006.

⇒ ***We know the most effective programs involve the consumers themselves.*** We continue to strengthen all of our consumer run programs. At Northern Nevada Adult Mental Health Services (NNAMHS) we began operation of a consumer run canteen using start-up money from the Community Mental Health Services Block Grant. This canteen has been running continuously since it opened and while not making a profit, its revenue has made it self-sufficient. Another program at NNAMHS is our Drop-In Center. This Drop-In Center provides refreshments, support, and psychoeducational classes for any consumer who wishes to participate. The Director of this program is a consumer who is also a State employee.

⇒ In FY 2004, NNAMHS acquired funding to support the ***Washoe County Mental Health Court.*** Prior to this, agency support for the Mental Health Court utilized existing resources. In FY 2004, the agency was authorized service coordination and residential support funding for the Mental Health Court. This allowed the Mental Health Court to expand its services and provide more integrated and coordinated treatment and monitoring for individuals supervised by the court.

⇒ Across rural Nevada we are making a difference as well. ***Our rural clinic program in Silver Springs implemented the use of telemedicine.*** Our services provide psychiatric services via computer-aided video conferencing. Telemedicine is proving to be an effective and efficient way to make mental health services available to rural Nevadans in the most remote areas of the state.

⇒ An aggressive recruitment campaign has been successful as shown by the lowest clinical vacancy rate in 10 years. ***Rural Clinics has also been able to open services in Overton and Wendover.***

Let me now turn to our Developmental Services (DS) programs. I could not discuss our DS programs without first acknowledging the leadership of our Division Associate Administrator for Developmental Services (DS), ***Dr. David Luke***. Dr. Luke's vision of all our people supported by the DS agencies, living in the community is fast becoming a reality here in Nevada. Thanks in no small part to Dr. Luke's guidance; MHDS has successfully developed innovative ways to help people live outside of institutional settings. Dr. Luke's hard work is responsible for much of the accomplishments of our DS programs over the past two years; let me mention a few of these DS successes;

⇒ In September 2004, Dr. Luke assisted my office in providing Nevada's first-ever statewide training to assist MHDS staffs who work with people with "dual diagnose"; that is people who face the challenges of living with both a mental illness and developmental disabilities.

⇒ The Governor awarded a **7% rate increase in FY04 and an additional 8% in FY05 (a total biennial increase of 15%) to our providers** of residential supported living services as well as Jobs and Day Training providers.

⇒ The rapid expansion of DS services to people who were on waiting lists. Waiting lists are monitored carefully and are reduced to zero whenever possible.

⇒ We have **strengthened our DS family support programs** that are designed to provide comprehensive services to individuals and their families in order for the family to remain intact. Intact, healthy families provide a support network for the person with the disability, resulting in a better quality of life. This also avoids expensive institutional or out-of-home supports.

⇒ We are proud to report that **all new residential DS supports are now being provided in the community**. Also in 2004, more than 200 families are now using a fiscal intermediary, which lets each person self direct their services and live independently.

⇒ DS services, using expanded satellite offices, in the rural areas, provide better local access for service coordination

⇒ All of Nevada's regional developmental centers have received **national accreditation** for outstanding services. This is another first for MHDS.

⇒ In-Home-Supported-Living-Services have been expanded to enable families who previously asked for out-of-home placement to keep their relatives at home.

However, even with all these successes, we cannot rest for a moment. Let me mention five of the most daunting challenges, which remain for us…

- Adequate acute care beds
- Completion of the MH MIS system
- Recruitment in rural/frontier areas
- Medication Inflation
- Suicide Prevention/Planning

In closing, let me say that now, more than ever, the participation of our stakeholders and policymakers is required to move our programs ahead cost effectively. More than ever, we need and appreciate your support.
Sincerely,

Carlos Brandenburg,
Ph.D.
Administrator
January 2005

From the Deputy Administrator

Division Deputy Administrator, Debbie Hosselkus, LSW

I was appointed the Deputy Administrator for the Division of Mental Health and Developmental Services in 1998. Throughout my six years in this position our staff has grown, the number of people we support has increased, and our vision for future services has expanded and improved. Our community based services are increasingly important and we have focused on giving the people we support the opportunity to live and work in the communities of their choice. I am delighted to have had the opportunity to participate in formulating and implementing the vision of our Division and I look forward to our continued growth, progress and planning for the future.

MHDS Mission

Our mission statement is an invaluable tool for directing, planning and achieving the Goals of the Division of MHDS.

In coordination with the mission statement, budgets are developed to assist with meeting the goals of the Division as well as ensure that we meet the needs of Nevada consumers.

Mission Statement for the Division of Mental Health and Developmental Services

Working in partnership with consumers, families, advocacy groups, agencies, and diverse communities, the Division of Mental Health and Developmental Disabilities provides responsive services and informed leadership to ensure quality outcomes. This mission includes person-centered services in the least restrictive, most inclusive (normative) environment. This includes prevention, education, habilitation, rehabilitation, and recovery for Nevadan's challenged with mental illness or developmental disabilities. These services attempt to maximize each individual's degree of independence, functioning, satisfaction, and self-sufficiency while ensuring the exercise of individual rights.

Division of Mental Health and Developmental Services Overview

The Division of Mental Health and Developmental Services (MHDS) provides services to over 26,000 Nevadans, 27,596 Mental Health clients and 3709 Developmental Services clients (total = 31,305 in Fiscal Year 2004) across 110,000 square miles of Nevada in both urban and rural areas. This is an increase of 12% from FY 2003. In addition to these direct consumers, the Division works with many stakeholders, including family members, advocates, service providers, legislators, the general public, and law enforcement. As a result of these diverse interests, the issues facing the Division, in addition to being complex, are also viewed from many different perspectives. The underlying thread of unity in this diverse system, however, is the commitment of all stakeholders to a public mental health/ developmental services system that meets the needs of Nevada's citizens.

The Division of MHDS is responsible for the operation of state funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services and all developmental services programs and facilities. By statute, the Division is responsible for planning, administration, policy setting, monitoring and budget development of all state funded mental health and developmental services programs. The Division Administration is also directly involved in decisions regarding agency structure, staffing, program and budget development. The mission of the Division is to develop and operate programs which assist individuals who have mental illness or developmental disabilities to live as independently as possible. The Division is obliged to offer care regardless of ability to pay, assure services are offered in the "least restrictive environment," base services upon individual needs, and honor consumers rights. The Division is committed to providing quality cost effective services that ensure consumer and citizen safety, are readily accessible to all persons in need, are responsive to local needs, are consumer-driven and promote self-sufficiency.

The MHDS Division is located within the Department of Human Resources. The Division Administrator, appointed by the Governor, relies on the oversight and direction of stakeholders as represented in several advisory groups. A Commission on Mental Health and Developmental Services is appointed by the Governor and "establishes policies to ensure adequate development and administration of services for the mentally ill, developmentally disabled and related conditions …" The Commission has several powers related to the oversight of programs within the Division. Local Advisory Boards exist within each region by authority of the Commission and are involved with local agency issues. Administration and services are organized into three regions: North, South and Rural.

DIVISION OVERVIEW

Elimination of Seclusion/restraint

Beginning in 2003,
-MHDS participated in a national initiative aimed at reducing and/or eliminating seclusion and restraint in mental health inpatient settings.
-MHDS staffs have been trained in techniques to reduce or eliminate the use of seclusion and/or restraint in our acute care programs.
We are now monitoring the data to ensure this effort is effective; and this work will continue

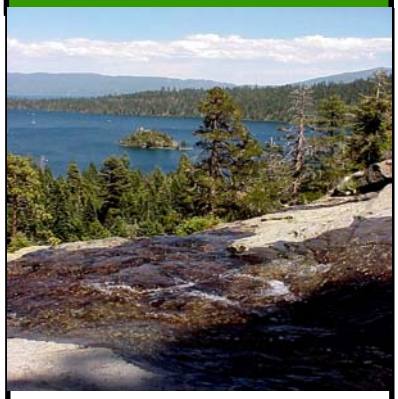
National Mental Health Goals (2002) Provided a Clear Direction for Nevada in 2004

-Nevada's efforts have been built upon President Bush's' national strategy (September 2002) to reform the national mental health delivery system.

-Nevada's Mental Health Implementation Plan was driven with the passage of SB 301 by 2003 Legislature.

-It was expressly designed to fully implement, in Nevada, the six National Commission Goals.

- Nevada is the only state that has developed such a state committee charged with achieving these national goals



MHDS
Strategic Plan
Goal #2:

Ensure that the vision, mission, budgets and service systems meet the expectation of the Olmstead decision in that services and programs are provided in the most normative setting .

Strengthen community-based services to support people with multiple and complex needs.

Mental Health:

The Division actual MH expenditures for Fiscal Year 2004 were $87,739,917 with 812 positions (FTE) funded. The general fund share of expenditures in FY 04 has increased by 21.5% over FY 02.

A full range of adult mental health services are provided by the Division which are categorized into the following programs by agency:

NNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services, Mental Health Court, Senior Outreach, HIV Outreach and Programs for Assertive Community Treatment (PACT).

Rural Clinics: Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, and Residential Programs. Rural Clinics also provides services to children and youth.

SNAMHS: Inpatient Services, Outpatient Counseling, Service Coordination, Medication Clinic, Psychosocial Rehabilitation, Residential Programs, Psychiatric Emergency Services, Intensive Service Coordination, Mental Health Court, Senior Outreach, Mobile Crisis , and two Programs for Assertive Community Treatment (PACT) programs.

Lake's Crossing Center (LCC): Nevada's only forensic facility, providing mental health treatment for the mentally disordered offender in a maximum security setting as well as Washoe County and Rural counties outpatient evaluations.

Since 1992, youth services have been incorporated into a separate Division of Child and Family Services within the Department of Human Resources. DCFS administers family support services, child care licensing, juvenile justice and an array of treatment services for youth in the urban areas of Clark and Washoe counties. However, in the remaining 15 rural counties, these youth services are offered via the Mental Health Division's system of rural clinics.

Since 1998, the foremost mental health service priority within the Division has been to provide services to consumers with serious mental illness (SMI). The Division in FY 97 revised the Nevada Administrative Code (NAC) to expand the state definition of seriously mentally ill. The definition for serious mental illness in the Nevada Administrative Code (NAC) reads:

> " Adults with a serious mental illness are persons 18 years of age and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder that meets DSM criteria (excluding the substance abuse or addictive disorders, irreversible dementias as well as mental retardation) which has resulted in functional impairment which subsequently interferes with or limits one or more major life activities.

'Functional Impairment' addresses the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health - illness and is viewed from the individual's perspective within their environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety."

Developmental Services

Developmental Services actual expenditures in FY04 were $74,563,139. This is an increase of 22.8% over the FY02 funding of $60,727,736 as state run institutions were downsized and services moved to the community. Positions declined 1.7% from 393.5 in FY02 to 387 in FY04.

Three regional centers provide services for people with developmental disabilities and related conditions throughout Nevada. In the Las Vegas area, Desert Regional Center offers community-based services in it's main office and three branch offices in Henderson, Pahrump and North Las Vegas. The largest state–run ICF-MR program is located on the campus near the main office. In the Reno area, Sierra Regional Center provides community-based services and is the location of the other state-run ICF-MR program in the state. Rural Regional Center, located in Carson City with satellite offices in Elko, Fallon, Silver Springs and Winnemucca, offers community-based services for the rural Nevada counties.

These programs provide a full range of services for people with developmental disabilities and related conditions and their families that include: Service Coordination, Family Support (respite, financial and other assistance), Jobs and Day Training, Residential Programs, and Quality Assurance. In Fiscal Year 2004, these programs served 3709 individuals.

The service vision for the Division's developmental services programs, "Developmental Services Vision for the year 2010", was developed based on stakeholder input.

The Division also seeks "to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports and other assistance and opportunities that promote independence, productivity, and integration and inclusion into the community (The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000)."

The service priority within the Division for developmental services has been to increase community-based living and work options and to reduce the need for people with developmental disabilities to be admitted to state institutions and congregate living facilities.

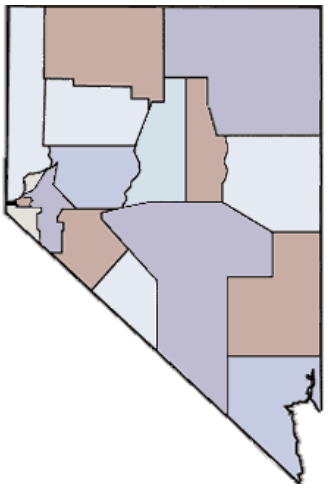
The number of people living in large state institutional centers has been decreasing over several years. The focus continues to be community and family supports.

DEVELOPMENTAL SERVICES

DESERT REGIONAL CENTER

RURAL REGIONAL CENTER

SIERRA REGIONAL CENTER



SERVICE LOCATIONS

MENTAL HEALTH & DEVELOPMENTAL SERVICES (MHDS)
505 East King Street, Room 602
Carson City, Nevada 89701-3790
Telephone (775) 684-5943
Faxes (775) 687-5966 & 687-5964
E-Mail: mhds@govmail.state.nv.us
Carlos Brandenburg, Ph.D., Administrator
Debbie Hosselkus, LSW, Deputy Administrator
David Rosin M.D., State Medical Director
Dave Luke, Ph.D., Associate Administrator for DS

SIERRA REGIONAL CENTER (SRC)
605 South 21st Street
Sparks, Nevada 89431-5599
Telephone (775) 688-1930
Fax (775) 688-1947
Dave Luke, Ph.D., Associate Administrator
For Developmental Services

DESERT REGIONAL CENTER (DRC)
1391 South Jones Boulevard
Las Vegas, Nevada 89146-1200
Telephone (702) 486-6200
Fax (702) 486-6334
Stan Dodd, LCSW, Clinic Director

RURAL REGIONAL CENTER (RRC)
1665 Old Hot Springs Rd, Suite 164
Carson City, Nevada 89706-0646
Telephone (775) 687-5162
Fax (775) 687-1001
Marcia Bennett, Ph.D., Clinic Director

LAKES CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER (LCC)
500 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-1900
Fax (775) 688-1909
Elizabeth Neighbors, Ph.D., Director

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
480 Galletti Way
Sparks, Nevada 89431-5573
Telephone (775) 688-2001
Fax (775) 688-2092
Harold Cook, Ph.D., Clinic Director

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)
6161 West Charleston Boulevard
Las Vegas, Nevada 89146-1126
Telephone (702) 486-6000
Fax (702) 486-6248
Jonna Triggs, Ed.D., Clinic Director

SNAMHS - Henderson Office
98 East Lake Mead Drive
Henderson, Nevada 89015
Telephone (702) 486-6700
Fax (702) 486-6708

SNAMHS - North Las Vegas Office
2121 North Las Vegas Boulevard
North Las Vegas, Nevada 89030
Telephone (702) 486-5750
Fax (702) 486-5769

SNAMHS - Southeast Office
1820 East Sahara Avenue,
Suite 109
Las Vegas, Nevada 89104-3736
Telephone (702) 486-8289
Fax (702) 486-8295

RURAL CLINICS: Administrative Office
503 North Division St.
Carson City, NV 89703-4104
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Larry Buel, Ph.D., Clinic Director

SERVICE LOCATIONS

RURAL CLINICS:

Battle Mountain Mental Health Center
10 East 6th Street/P.O. Box 50
Battle Mountain, NV 89820-0050
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David Dummar, MFT

Carson Mental Health Center
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Carson City, NV 89706
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Sueann Bawden MFT, Clinic Director

Dayton Mental Health Center
120 Pike Street/P.O. Box 1597
Dayton, NV 89403-1597
(775) 246-5240; (775) 246-5364 Fax
Patty Hill, LCSW, Clinic Director

Douglas Mental Health Center
1538 HWY 395 N, Gardnerville, NV 89401-5239
(P.O.Box 1509, Minden, NV 89423-1509)
(775) 782-3671; (775) 782-6639 Fax
Tom Embree Ph.D.,MFT, Clinic Director

Elko Mental Health Center
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Elko, NV 89801-2558
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Greg Pomerleau LCSW, Clinic Director

Ely Mental Health Center
1665 Avenue F/P.O. Box 151107
Ely, NV 89315
(775) 289-1671; (775) 289-1699 Fax
Lynn Freeman, LCSW, Acting Clinic Director

Fallon Mental Health Center
151 North Main Street
Fallon, NV 89406-2909
(775) 423-7141; (775) 423-4020 Fax
Dolly Coke, LCSW, Clinic Director

Fernley Mental Health Center
115 West Main Street/P.O. Box 2314
Fernley, NV 89408-2314
(775) 575-0670; (775) 575-0672 Fax
Patty Hill, LCSW, Clinic Director

Hawthorne Mental Health Center
1000 "C" Street/P. O. Box 12
Hawthorne, NV 89415-0012
(775) 945-3387; (775) 945-2307 Fax
Dolly Coke, LCSW, Ph.D., Clinic Director

Lovelock Mental Health Center
775 Cornell Ave. Suite #C/P.O. Box 1046
Lovelock, NV 89419-1046
(775) 273-1036; (775) 273-1109 Fax
Dolly Coke, LCSW, Ph.D., Clinic Director

Mesquite Mental Health Center
61 N Willow Suite 4 /P.O. Box 3567
Mesquite, NV 89024
(702) 346-4696; (702) 346-4699 Fax
RJ Turner, Ph.D., Acting Clinic Director

Pahrump Mental Health Center
240 S. Humahuaca PO Box 5756
Pahrump, NV 89048
(775) 751-7406; (775) 751-7409 Fax
Sue Haut, LCSW, Acting Clinic Director

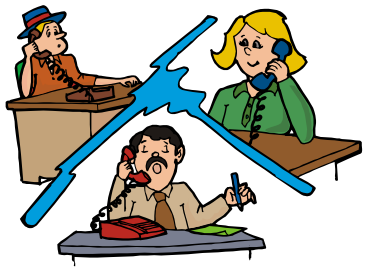
Silver Springs Mental Health Center
3595 Highway 50 East/P.O. Box 1136
Springs, NV 89429-1136
(775) 577-0319; (775) 577-9571 Fax
Patty Hill, LCSW, Clinic Director

Tonopah Mental Health Center
825 S Main P.O. Box 494
Tonopah, NV 89049-0494
(775) 482-6742 & 482-9819 Emergency
(775) 482-3718 Fax

Winnemucca Mental Health Center
3140 Traders Way/P.O. Box 230
Winnemucca, NV 89446-0230
(775) 623-6580; (775) 623-6584 Fax
David Dummar, LMFT, Clinic Director

Yerington Mental Health Center
310 Surprise Avenue
Yerington, NV 89447-2542
(775) 463-3191; (775) 463-4641 Fax
Patty Hill, LCSW, Clinic Director

STAKEHOLDERS



Stakeholder Values

Community Integration:
Consumers contribute to the community through positive behavior.

Consumer Involvement:
Consumers are educated about their disorders and actively involved in their treatment.

Consumer Satisfaction:
Consumers feel good about the kinds of services received.

Family Support:
Consumers' families are informed and involved.

Safety:
Consumers and the community are safe from the consumers behavior.

MHDS-MENTAL HEALTH SERVICES:

Involving Stakeholders in Planning and Evaluation

MHDS directly involves its stakeholders in the planning and quality improvement of its mental health programs. Consumers, family members, legislators, and mental health professionals, as well as representatives from the courts and correctional fields, have been formally involved in the definition of values that underlie the mission of the Division and guide the strategic planning of the mental health programs. The general community is also invited to participate in strategic planning meetings, and has been instrumental in defining the mission statements of the agencies. These stakeholders are regularly updated on the progress made toward the goals and objectives of the Division.

A primary way we have strengthened the involvement of consumers is by our increasing collaboration with the Nevada Mental Health Planning Advisory Council (MHPAC). The Council is a 17-member group established in 1989 with the goal of serving as an advocate for people with chronic mental illness, children and youth with severe emotional and disturbance, and other individuals with mental illnesses or emotional problems. By federal mandate, greater than 50% of the members of the Council must be non-State representatives that include consumers of mental health services, family members, and other mental health advocates. The MHPAC works with the Division in a variety of ways, all of which are designed to involve consumers in the development and delivery of mental health services here in Nevada.

Since the beginning of the program in June of 2002 ***The Consumer Assistance Program*** has made great strides in providing services to the consumers and families of MHDS. The consumer assistance program began with one full time statewide program coordinator and seven full time consumer service assistant located at SNAMHS (2) NNAMHS(2) Douglas Mental Health (1) and Carson Mental Health (1). The Program has increased with the addition of (2) new staff located at SNAMHS, and (1) in Winnemucca

The program provides services throughout the State. In the rural areas the services that are provided to consumers include:

- Transportation to appointments
- A variety of groups such as
  - ***All about food***-providing information on comparing pricing during shopping.
  - Understanding and using recipes in daily cooking.
  - ***Exercise group***-providing consumers with different exercise that can be done in groups, with a partner or alone.

Life Learning Skills- provides consumers needed skills to live independently in the community.

- ***Assistance with Social Security*** issues for consumers receiving social security and consumers that are just beginning the application process.
- ***Home Visits***- to consumers who may be ill and can not attend appointments.
- ***Crisis Intervention***

At Northern Nevada Adult Mental Health the program provides:

- A Drop in Center- where consumers go to socialize with others. The center also provides a hot meal once per week and daily snacks.
- A variety of groups such as

Understanding Depression **-** providing consumers an opportunity to discuss their own issues on depression.

Our Time- this is a time where the consumers discuss social issues and learn to prepare food and use recipes. This group also teaches consumers to understand sales and the benefit of clipping coupons.

Walking Club– Consumers walk 3 days a week.

Peer to Peer Support Groups- this is a time when consumers come together and discuss the issues that they are having and work on problem solving together.

At Southern Nevada Adult Mental Health the program provides:

- A variety of groups such as

Healthy Works **-**providing consumers with information on diet and exercise. There are a variety of activities that occur in this group including basketball, kickball, tennis and general exercise activities. Activities for the day are chosen a month in advance by consumers and placed on a monthly activity calendar.

Understanding our medication-this is a time where the consumers discuss medication compliance and why it is important. Consumers also have the opportunity to understand each of their own medications and the role it plays in their recovery. Consumers learn the refill process that includes discussing medication issues with their doctors, how to schedule appointments and the importance of keeping appointments. Consumers also learn how to coordinate psychiatric and medical appointments and medications.

Crafts-Consumers have the opportunity make gifts for family members, friends and others in the community.

Peer to Peer Support Groups-this is a time when consumers come together and discuss the issues that they are having and work on problem solving together.

CONSUMER SURVEYS

Inpatient Survey Results:

>The medications I am taking help me control the symptoms that used to bother me:
NNAMHS = 68.5% agree/strongly agree
SNAMHS = 76.5% agree/strongly agree

> My other medical conditions were treated:
NNAMHS = 59.4% agree/strongly agree
SNAMHS = 46.2% agree/strongly agree

> The hospital environment was clean and comfortable:
NNAMHS = 83.5% agree/strongly agree
SNAMHS = 77.9% agree/strongly agree

Outpatient Survey Results:

>General Satisfaction:
NNAMHS = 80% agree/strongly agree
Rural Clinics = 95% agree/strongly agree
SNAMHS = 89% agree/strongly agree

> Treatment Participation:
NNAMHS = 81% agree/strongly agree
Rural Clinics = 87% agree/strongly agree
SNAMHS = 84% agree/strongly agree

> Outcomes:
NNAMHS = 64% agree/strongly agree
Rural Clinics = 67% agree/strongly agree
SNAMHS = 78% agree/strongly agree

> Appropriateness:
NNAMHS = 78% agree/strongly agree
Rural Clinics = 86% agree/strongly agree
SNAMHS = 83% agree/strongly agree

> Access:
NNAMHS = 78% agree/strongly agree
Rural Clinics = 90% agree/strongly agree
SNAMHS = 85% agree/strongly agree

CONSUMERS

MHDS Strategic Plan Goal #3**:**

Ensure that services are consumer-drive in that services address the interests, rights, and needs of each individual consumer (individual served).

Stakeholder Values

(continued from Page 14)

Improved Social Functioning: Consumers make progress in work, school and relationships.

Personhood: Consumers have worth and dignity.

Skilled Coping: Consumers gain skills needed to handle the problems of life.

Symptom Reduction: Consumers symptoms are reduced, stabilized or prevented.

Independent Living Skills-provides consumers with skills needed to live independently in the community such as bill paying, money management and budgeting. We also work with consumers on apartment setup, utility installation, and opening and managing a bank accounts.

Pathways to Recovery-This group works with consumers to acquire the tools that are needed to work and live in their recovery.

Activities Group-Provides consumers with the opportunity to do things as a group within the community such as going to museums, bowling, movies, and shopping.

Nutrition-Provides information for consumers to make healthy food choices, alternate food choices, and provides information on following recipes and serving food.

Anger Management-Consumers work together on anger issues and give suggestions on ways of dealing with anger in a healthy manner.

Work readiness-This includes résumé writing, application process, interviewing skills, dress for success and work ethics.

At Southern Nevada Adult Mental Health Services, the consumer assistance program was implemented This program provides training in a variety of areas and assisted consumers in locating and maintaining employment. As a result of this program, 7 consumers have been employed. Other services are provided such as advocating for consumer rights, assisting with Social Security issues, Social Services, Welfare, Ticket to Work and Court appearances. Other assistance includes:

- Release planning while incarcerated
- Assistance to access services at SNAMHS
- Work referrals and Job Readiness
- Benefit applications
- Assistance to be successful with terms of Parole

In the upcoming years the goal is to add more CSA's to work in areas such as PACT, Service Coordination, and to have a CSA at all clinic sites to expand advocacy training and to certify all CSA's.

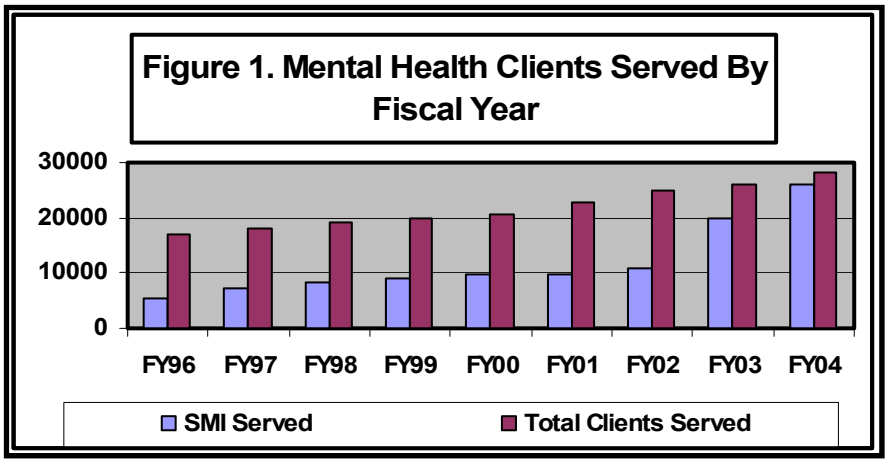
The following programs may be added or expanded:

- ***Community and Outreach Programs***- providing more assistance to consumers in their community environment.
- ***Internship***- This program allow consumers to obtain the skills they need to become full time Consumer Services Assistants.
- ***Volunteers***– Provides the opportunity for consumers to become volunteers in all agencies..

Who are the Recipients of Mental Health Services?

The Division of Mental Health and Developmental Services directly provides or coordinates the provision of contracted adult public mental health services in Nevada. MHDS Rural Clinics also provide services to children and families. Inpatient and outpatient programs are provided primarily on a fee for service basis since people with serious mental illness have been "carved out" of the State's managed care structure.

The Center for Mental Health Services[1] estimates that 7.2% of the population in Nevada will suffer from a severe mental illness during their life. More recently, a study [2] ranked Nevada as the number one state in the Western United States for prevalence of mental illness, estimating that as much as 23.7% of the population in Nevada will have some form of diagnosable mental disorder during their life. It also estimated that approximately 1.8% of Nevadans are currently functionally impaired because of a serious mental illness. **Figure 1** shows the growth in individuals served over the last seven fiscal years.
Table 1 shows the breakdown by agency for FY03 and FY04.
Figure 2 shows percent of consumers by agency.



1 *Estimation of the 12-Month Prevalence of Serious Mental Illness*, CMHS Draft, Kessler, et al. 1997.
2 *Needs Assessment in the West: a Report on a Workshop and Subsequent Analysis* (WSDSG, 1998)

CONSUMERS

MHDS Strategic Plan Goal #4:

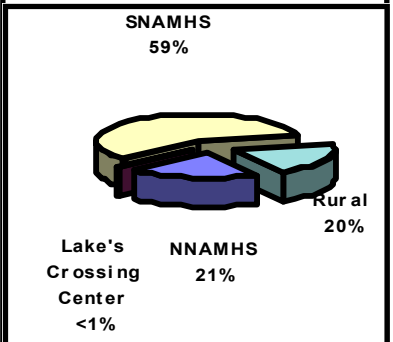
Utilize technology to improve accessibility to, and availability of services and the efficient use of resources.

MHDS Strategic Plan Goal #5:

Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.

MENTAL HEALTH SERVICES

Figure 2. Percent of Total Clients Served by Agency FY04



MHDS Strategic Plan Goal #6:

Reduce the rate of suicide and other riskful behaviors in Nevada, which can cause injuries, death, etc.

Table 1. Unduplicated Clients Served: Percent Growth

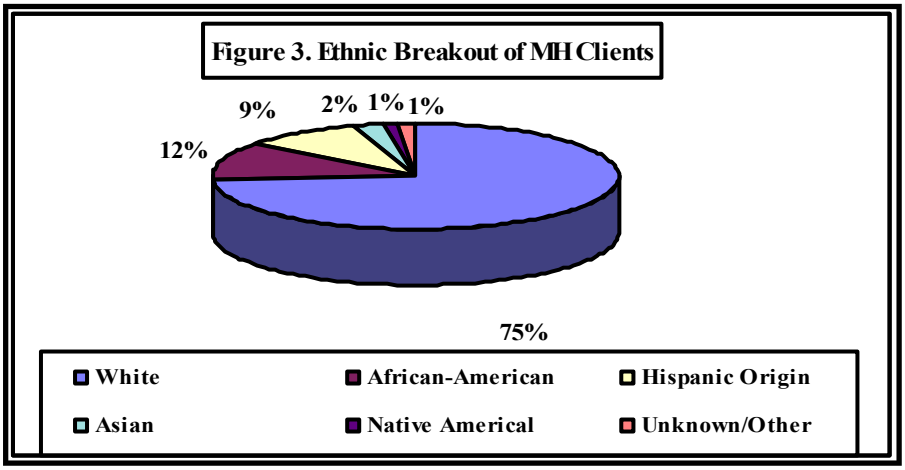
	FY03	FY04	%change
Lakes*	449	683	+52%
NNAMHS	5192	5669	9%
SNAMHS	13374	15779	18%
Rural Clinics	4934	5465	11%
TOTAL	23949	27596	15%

** Includes outpatient services which will be counted in future "persons served totals".*

With the exception of MHDS' forensic facility, the state demography shows an equal split between male and female, and MH shows a consumer ratio of 56% female to 44% male. In 2004, 56 percent of the consumers served by SNAMHS and 47% of Rural Clinics' consumers are between 21 and 44 years of age. MHDS only serves children through its Rural Clinics, where they comprise 22% of the client base. The demographers estimate for the percentage of children in the state is 27%.

Approximately one third of the consumers have never married, and most claim only themselves as a single dependent. More than one third are unemployed.

Approximately 75% of MHDS' consumers are white which is comparable to Nevada's population figure of 64% projected for FY04. **Figure 3**, details MHDS' breakout of clients by ethnicity. The largest

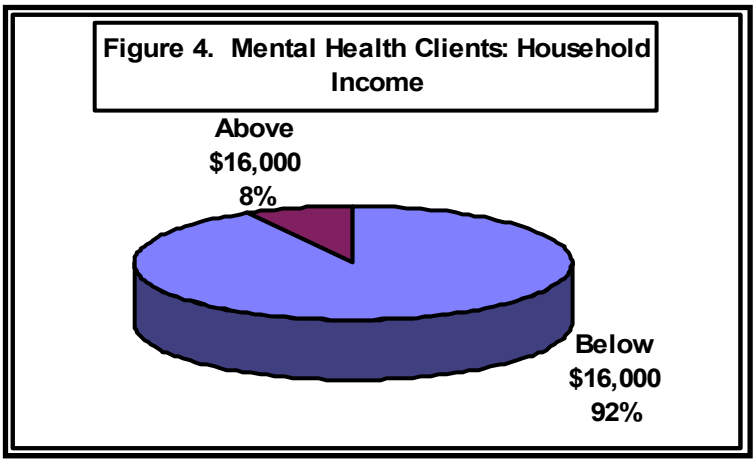


Note, although included, Hispanics are an ethnicity, not a race. MHDS Rural data included in breakout comparison.

3. Division Demographics are based on FY2004 data analysis .

category of racial minorities served at Nevada's urban mental health centers are African Americans. In contrast, Native Americans are the primary racial minority in MHDS rural mental health clinics. Ethnically, approximately 9% of the State's public mental health consumers are Hispanic. The state demographer estimates that Hispanics (Hispanic Origin of any race) will comprise around 22% of Nevada's population in 2004.

It is estimated that in 2004, 10.3% of all Nevadans lived below the poverty level. This contrasts sharply with the consumers of Nevada's public mental health services. As a rule, the people who come for mental health service are from lower income brackets, with approximately 92% of MHDS' consumers earning below $16,000 per year. **Figure 4** shows percent of clients below $16,000 in income. In 1999 7.5% of Nevada families were below the poverty level.



Note: This data excludes the unknown category

Generally, people come to MHDS' locations for treatment of a few primary disorders: major depression, psychosis, bipolar or schizophrenic episodes. Outpatient consumers show a wider range of treatment needs. Seventy six percent of outpatient clients fall into several categories: adjustment disorders, mood disorders, major depression, dysthymia, and schizophrenia. Around 10% of our outpatient consumers have a co-occurring diagnosis, suffering from both mental illness and substance abuse.

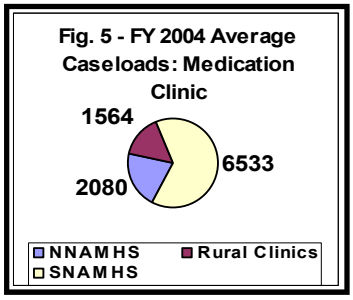
The 1200 children who were served by the Division's Rural Clinics primarily sought service in FY 04 for help with depression (10.8%), attention deficit (33%), bipolar (3.3%) adjustment disorder (31.8%), and anxiety (6.9%).

MENTAL HEALTH SERVICES

HIPAA
Health Insurance Portability and Accountability Act

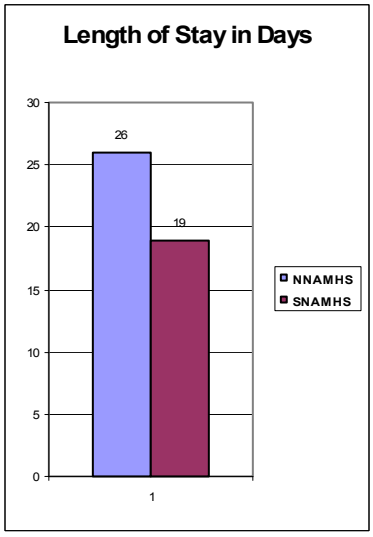
- The MHDS HIPAA Compliance Officer began working at the Division in January 2004.
- The MHDS HIPAA Compliance Officer oversees all ongoing activities related to MHDS policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the health organization's information privacy practices.
- To date there has only been one HIPAA complaint filed with the Office of Civil Rights (OCR) in 2004. This complaint was resolved by sending a memorandum of explanation to OCR.
- The MHDS HIPAA Compliance Officer is now in the process of developing information technology security policies to comply with the federal deadline of April 20, 2005.

MEDICATION CLINIC



INPATIENT SERVICES

Inpatient Services
Length of Stay in Days

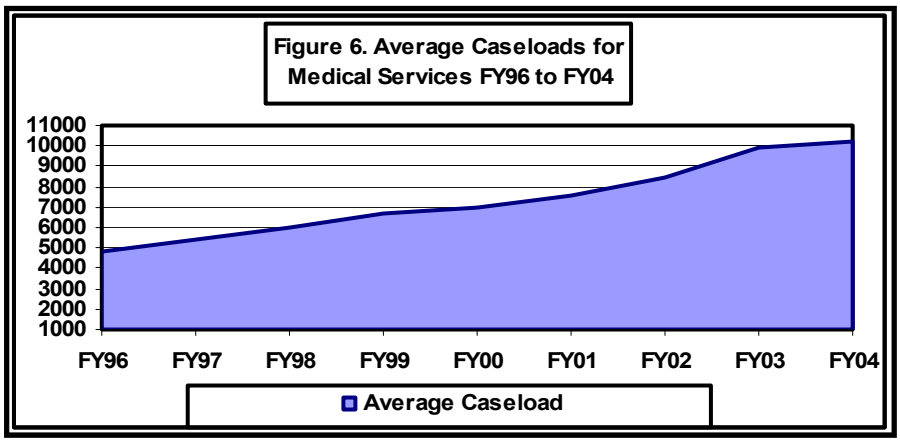


MENTAL HEALTH PROGRAMS

Several levels of mental health care are provided through inpatient and outpatient programs. Consumers requiring intensive care are supported by inpatient services and intensive outpatient programs. Other outpatient programs help the consumer gain greater independence, confidence and ability to function in the community.

The Role of New Medications: The Division's medication prescription services are provided by a psychiatrist or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services also include pharmaceutical counseling and education provided by a pharmacist. Since the use of medications is a foundation of treating most mental illnesses, the medication clinic is the Division's largest treatment program (**Figure 5** shows the medication clinic's persons served by agency. **Figure 6** shows program growth). Medication costs account for $16,774,451 or 19% of the FY04 Mental Health budget.

Newer antidepressant and anti-psychotic medications have fewer negative side effects than older medications. While they cost more, they benefit consumer functioning, quality of life, and reduce the demand and duration of other expensive treatment forms. These medications also minimize relapses and subsequent re-admissions to the hospitals. The Division has increased funding for these new medications so the consumers can have access to them.

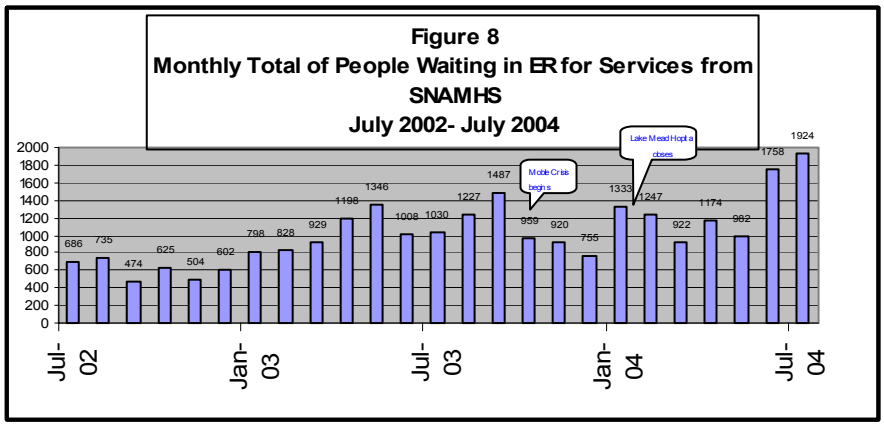


Inpatient Programs:

Inpatient facilities at the Northern Nevada Adult Mental Health Services (Dini-Townsend Hospital) and Southern Nevada Adult Mental Health Services (Muril H. Stein Hospital) focus on consumer recovery and stabilization.

For example, at SNAMHS, individuals in crisis may be served by programs offered at the Psychiatric Emergency Services (PES) unit. The outpatient program, Psychiatric Ambulatory Services (PAS), provides 24 hour emergency walk-in center service for clients

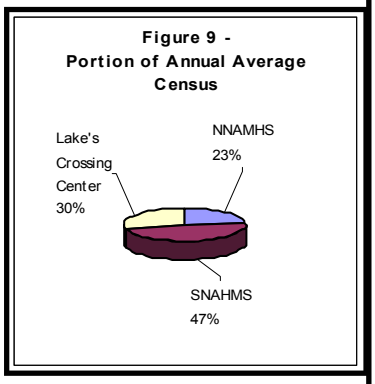
in crisis while the Psychiatric Observation Unit (POU) provides emergency treatment in a 72 hour observation unit for consumers needing short term observation, stabilization and treatment in a secure environment. As a result of the enormous growth in Clark County during 2004 a daily average of 42 consumers requiring emergency psychiatric care waited in the valley's emergency rooms or jails on involuntary legal holds an average of 61 hours each before they could be admitted to the POU for services. The POU currently has a capacity for 26 patients. The provision of psychiatric emergency services allows consumers in crisis to be stabilized and avoid admission to the hospital. The positive effect of this program is shown by the fact that 48% of the nearly 3000 consumers admitted to the SNAMHS POU during fiscal year 2003 were stabilized and avoided hospitalization. The average length of stay for SNAMHS patients on the inpatient unit is 19 days. **Figure 7** (previous page – sidebar) compares the average length of stay between SNAMHS and NNAMHS for inpatient. **Figure 8** shows the monthly total of people waiting in ER for services from SNAMHS. It also shows a drop in patients waiting, with the full implementation of the Mobile Crisis Team in October 03, rapidly followed by an increase with the closure of the psychiatric inpatient unit at Lake Mead Hospital. **Figure 9** (sidebar) shows the portion of inpatient consumers served at each of the hospitals.



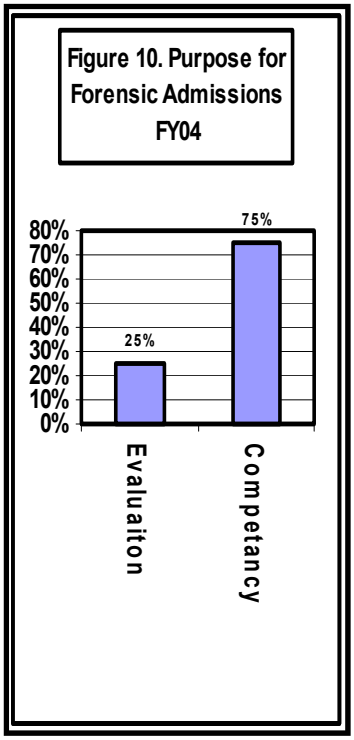
Forensic Services: Forensic Services: Lake's Crossing Center (LCC) was designed to serve the mentally disordered criminal offender, to evaluate competency to stand trial, assess criminal responsibility and/or provide recommendations for treatment, and treatment to competency and recovery for Not Guilty by Reason of Insanity (NGRI) Acquittees. (**See Figure 10**). Services include clinical assessment, forensic evaluation and short or long term treatment, as appropriate, based on the nature of the court commitment. Ninety-nine percent of the consumers are sent to LCC by the courts for treatment to establish competency to stand trial or for initial competency evaluation. (Figure 10) Another small percentage of clients are Not Guilty by Reason of Insanity Acquitees/Administrative Transfers. The relationship between this agency and the court and legal system is defined in NRS Chapter 178 and 175.

PROGRAMS AND SERVICES

INPATIENT SERVICES



FORENSIC SERVICES



PROGRAMS AND SERVICES

PACT

The Program for Assertive Community Treatment uses a multidisciplinary mental health team to provide customized mental health services.

ISC

Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada

The 48 bed Center served 135 inpatient clients in 2003 and 116 clients in 2004. These numbers have declined slightly in the last two years in part due to larger numbers of assessments being completed outpatient and due to increasing length of stay. It is likely the length of stay has increased due to the increased severity of mental illness in client referrals and due to changes in the law that make it more difficult to treat clients unless they accept medication voluntarily. One example of change in the law that impacts these factors is the Supreme Court Case U.S. v. Sell.

As an average in FY 2003, client length of stay was 115 days but increased to 135 days in 2004. In 2003 admissions were relatively evenly distributed around the state. Forty-eight percent of admissions were from the south, with 17% from Washoe County and 35% from the rural counties. In 2004 53% of the admissions were from Clark County, 27% from Washoe County and 20% from the rural counties. The census did not peak above facility capacity during this biennium. The facility has capped the census and will not accept clients over the specified 48 bed capacity. This policy has generated periodic waiting lists that have accumulated up to 15 defendents waiting for treatment in detention centers. The reason for the need to cap the census is directly related to the safety of staff and clients within the facility. As the density of population increases assaults and injuries for both staff and clients rise. This increase in violent incidents was documented during times when the census rose to 62 and a decline was documented when the census was reduced to the 48 beds the facility was designed to accommodate.

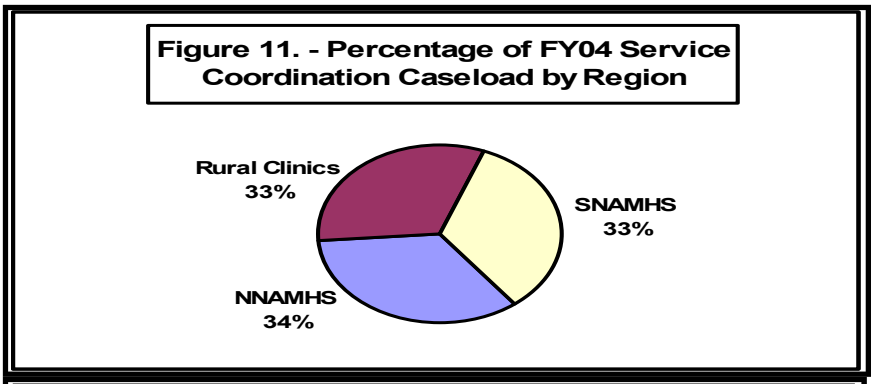
In 2003 35% of the inpatient admissions were per NRS 178. 415. (These are individuals who are not committed as Incompetent to Stand Trial, but whose initial evaluation of competency must be done in an inpatient setting.) In 2004 25% were admitted for these evaluations.

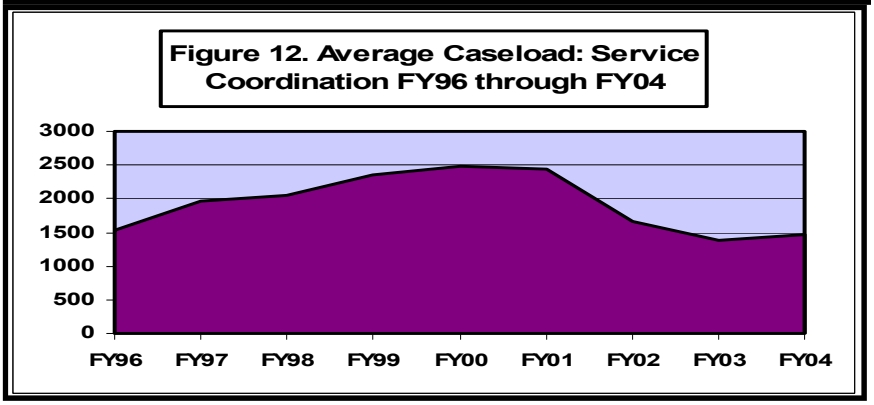
Over the last five years the numbers of outpatient clients have increased dramatically. The facility has focused on completing as many evaluations as possible as outpatients. These evaluations are done for individuals from the rural counties and for Washoe County through the Interlocal Agreement maintained with Washoe County. During 2003 LCC completed 282 evaluations outpatient from both Washoe and the Rural Counties. In 2004, 554 evaluations were completed outpatient.

The increased demand for outpatient evaluations has decreased the number of inpatient evaluations the facility has needed to perform. It is anticipated, however, that inpatient commitments will continue to increase over time due to increased population and the reimplementation of the Not Guilty By Reason of Insanity Law.

Outpatient Programs with an Intensive Care Focus:

Program for Assertive Community Treatment (PACT): This program provides intensive community based treatment and rehabilitation services to consumers with serious mental illness by using a multidisciplinary mental health team to provide these services. The goal of the program is to reduce debilitating symptoms and minimize or prevent recurrent acute episodes of illness. Continuous rather than time limited service and interventions tailored to each consumer characterize this program. Nationally, the PACT model has shown participants to have longer and more productive community tenure and be better able to manage their impairment upon discharge from the program.





This program started serving clients at Southern Nevada Adult Mental Health Services campus in March 1998. Southern Nevada Adult Mental Health Services currently has two PACT teams. The newest team added during 2003 specifically targets seriously mentally ill homeless individuals living in Clark County. Each team carries a caseload of 72 consumers. Northern Nevada Adult Mental Health Services began this program in Fiscal Year 1999.

Intensive Service Coordination: Intensive service coordination provides more intensive care for forensic consumers in Southern Nevada. This growing number of people tends to have numerous and long term hospital stays as well as extended time in jails and/or prison. Each day a patient is in the hospital ($389/day) or jail/prison (approximately $90/day) is extremely costly for the state. These

Service Coordination

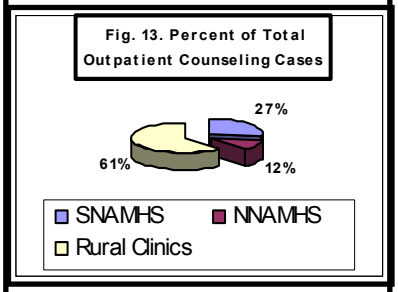
There are many models of community care for persons with mental illness.

The Division policy 3.002 defines this service as:

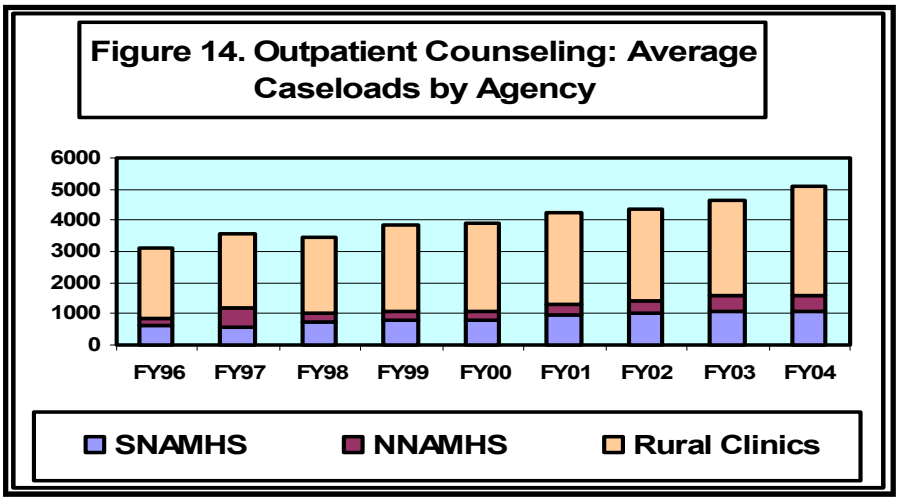
- *Arrange access to needed service.*
- *Assure efficient and timely coordination of services.*
- *Maximize the client's capacity to benefit from services and to function independently.*
- *Limit unnecessary restrictive treatment.*
- *Mobilize the support of family, friends and advocates.*

OUTPATIENT SERVICES

Outpatient Counseling



patients need intensive assistance to develop independent living skills, medication compliance, social skills, employment skills, and anger management processes to reduce or eliminate violent or criminal behaviors. The goal of ISC is to assist the consumer in achieving and maintaining the highest level of independent functioning possible, while reducing time spent in either the hospital or in jail/prison. The program began serving consumers at SNAMHS in December 1997. Since that time, the average monthly caseload has more than quadrupled, growing from 11 initial consumers to a total monthly average of 51 at the end of 2003 with a waiting list of 20. The program is budgeted to support a caseload of 45 people.



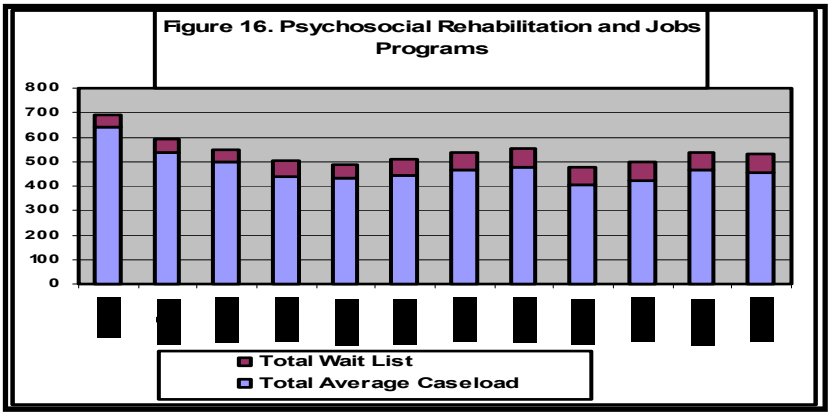
Mobile Crisis Team: This team was funded during the last legislative session and was fully implemented in October, 2003. The Mobile Crisis Team (MCT) is a specialized unit, available only at Southern Nevada Adult Mental Health Services, that works with the Las Vegas area hospital emergency departments. The MCT is comprised of Licensed Clinical Social Workers who travel to local hospital ERs to evaluate their psychiatric patients and, if feasible, develop safe discharge plans, which they present to the ER physicians for approval. This service averts unnecessary psychiatric hospitalizations, saves ER personnel time, and reduces the number of psychiatric patients in the ERs.

Outpatient programs focusing on increasing consumer independence:

Service Coordination : Service Coordinators coordinate treatment and assist individuals in accessing services and choosing service opportunities based on a treatment plan developed with the client. They assure that consumers access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement and other essential community resources. They also help mobilize family, community, and self-help groups on the consumer's behalf.

They may provide direct treatment to consumers when none is available through referrals or community agencies. MHDS' Service Coordination caseload averaged around 498 cases at NNAMHS, 475 cases at Rural Clinics and 523 cases at SNAMHS. Additionally, Mojave Adult, Child and Family Services (University affiliated provider under contract to MHDS) served an average monthly caseload of 753 people. (**Figure 11,** page 23**,** shows service coordination case distribution, **Figure 12,** page 23 – caseload over last nine years).[4]

Medication Clinics: Provides outpatient adult psychiatric, nursing and direct medication services, including prescribing and dispensing both injectable and oral medication. The latest, most effective medication is prescribed and dispensed through agency pharmacies. The services include limited and focused consultation with the patient about medication treatment, and referrals to other agency services. All four site offices at Southern Nevada Adult Mental Health Services provide medication clinic services. The caseload at



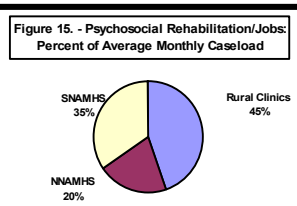
the end of 2003 was 6,358. This does not include the approximate 502 consumers who must get their medications and psychiatric support services from the Psychiatric Emergency Services staff because of the long wait for a scheduled appointment at one of the site offices which are usually booked 3-4 months in advance.

Outpatient Counseling: Outpatient counseling services provided to individuals include diagnosis and evaluation, counseling, psychotherapy, and behavioral management. These programs focus on developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. Specialized services are provided to families and couples to facilitate communication between patients and family members. Group counseling sessions include activity therapy as well as psychotherapy to help guide consumers through interpersonal conflict and improve positive communication. Outpatient Counseling, Rural Clinic's primary program, serves as the foundation program for all of its consumers. NNAMHS and SNAMHS may admit consumers into other programs, such as Service Coordination, without first seeing a counselor. **Figure 13**-(left side-bar) shows the portion of outpatient

4 This does not include clients at Mojave Adult, Child and Family Service

OUTPATIENT SERVICES

Psychosocial Rehabilitation



Increase Psychiatric Emergency Services (PES) in Las Vegas -

We strengthened our Emergency Services Unit in Las Vegas by expanding the number of emergency observation beds and alleviate the community emergency room crowding.

OUTPATIENT SERVICES

Evidence Based Practices.

• Evidence based practices (EBP), are therapeutic approaches, which have been proven to be effective in working with people who struggle with serious mental illnesses.

• Some of EBP programs MHDS currently offers include:

> PACT Consumer Assistance Programs and consumer/family involvement.

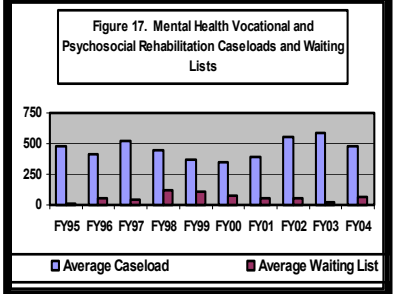
> Supportive living arrangements. Medication management, including use of medication algorithm.

•Other EBPS that Nevada is working to begin using include

> Supported employment

> Family psycho education.

> Dual Diagnosis treatment.



counseling consumers served by agency. **Figure 14** shows 9 years of counseling caseloads. This past year Southern Nevada Adult Mental Health Services, funded through a Ryan White Title I Grant made available from the US Department of Health and Human Services and the Clark County Health District began providing outpatient counseling services to serious mentally ill consumers also affected by HIV/AIDS. The intent of this program is to maintain an individual's mental health at a level that affords them the ability to fully participate in their primary medical care plan

Psychosocial Rehabilitation and Vocational Programs:

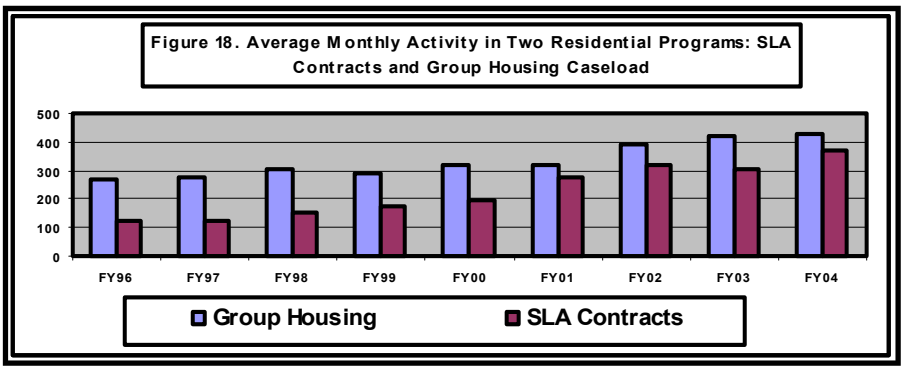
Psychosocial rehabilitation is targeted to consumers in need of an active treatment environment to foster their independence in the community. The goal is to maximize an individual's level of functioning in the community and to prevent acute inpatient care. Emphasis is placed on acquiring skills in the following areas: survival and adaptation, symptom and medication management, problem solving, grooming, financial management, prevocational services, and management of leisure time. Programs are individualized for the consumers. Some services are provided under contract and may take place in a classroom setting or at the consumer's residence. **Figure 15** (previous page) shows each agency's portion of the psychosocial rehabilitation caseload. **Figure 16** (previous page) shows program caseload and wait list during Fiscal Year 2004

Vocational programs include vocational guidance and counseling, and transitional planning. They also provide an array of skills training through school, peer advocacy, world of work classes through BVR and on the job training and apprenticeships. This program assists with job seeking skills and provides support during job seeking as well as through the State's Bureau of Vocational Rehabilitation (BVR). Consumers are assisted through vocational assessment, work adjustment training and post-employment services designed to maintain employment by focusing on decision making, problem solving and establishing natural community supports. Additionally, joint efforts between MHDS and the BVR provide collaborative assistance to help consumers achieve their vocational goals. Staff from BVR are co-located with staff from Southern Nevada Adult Mental Health Services at the main campus in Las Vegas.

These programs are in demand by consumers as can be seen by their waiting lists for services (**Figure 17**). The Divisional annual average caseload (Vocational and Psychosocial Rehabilitation programs combined) in Fiscal Year 2004 was 475 clients.

Residential Supports:

Group housing: These are group residential programs for clients who do not require specialized intensive services but require a structured living arrangement in the community with supports for daily living in the least restrictive setting. The Division's average annual caseload is approximately 457 clients (see **Figure 18)**.



Supported Living Arrangements (SLAs): These living arrangements are intended to be flexible and offer housing based on consumer choice and individualized services tailored to the consumer's needs so that services have a "wrap around" effect and encompass the capabilities of the consumer. Consumers, families and agencies collaborate in the development of a plan that will place the client in an independent and *least restrictive setting*. The program includes purchased community SLA's, contract services and the HUD Shelter Plus Care program for homeless mentally ill people. **Figure 18** compares the seven year average group housing caseloads to the average number of SLA contracts.

Specialized Residential - These community based living programs provide support and/or skills training for residents with specialized service needs who also need non-institutional psychiatric services. These programs include the least restrictive arrangements that are specially designed to meet the needs of the following special populations with mental illness or substance abuse behaviors, people with medical problems, senior citizens requiring assistance, consumers with severe behavioral symptoms, and deaf consumers.

Intensive supportive living arrangements (ISLAs) - They provide 24-hour awake supervision of clients who otherwise would require inpatient hospital care. These services are provided in independent apartment community settings or private homes with additional individualized support services based on client needs, choice and least restrictive setting.

Special Needs Beds—They provide independent apartment community settings for medically challenged mentally ill clients who require additional nursing supervision. These placements provide service to clients who otherwise would have remained in the inpatient psychiatric hospital only because self care of their medical condition is compromised by mental illness.

Geriatric Services: These services are supported through grants from the Division of Aging Services and the Bureau of Alcohol and Drug Abuse to Southern Nevada Adult Mental Health Services. People are referred by the Division of Aging Services.

RESIDENTIAL SUPPORTS

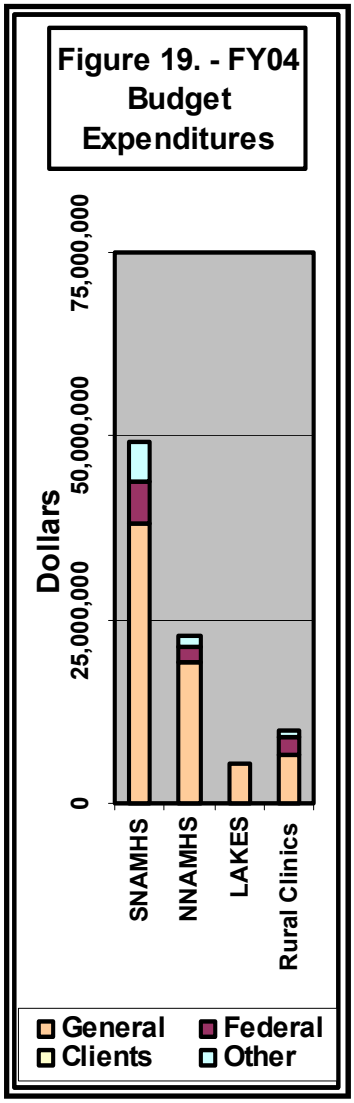
Community Residential Services

- MHDS began the state-wide residential support coordinator in June 2004
- MHDS agencies received funding from FY03 Legislature for additional sheltered living arrangement (SLA's) to accommodate caseload growth
- We converted existing institutional systems to provide more community based supported living arrangements.
- Additional SLA's will allow MHDS to significantly reduce the severity of the homeless, indigent mentally ill problem by providing housing and support for these individuals.

FUNDING SOURCES

Mental Health Funding Sources and Expenditures

In fiscal year 2004, MHDS operations cost $165,339,414. In fiscal year 2005 a total of $194,976,376 is budgeted for operations. Of this money the majority (67%) comes from Nevada's state general fund. The general fund share of expenditures in FY 04 has increased by 21.5% over FY 02. Most of the remaining funds are Federal (27%), with revenue from consumers and other sources making up 6% of the total. Only 2% of the amount budgeted is used for central administration. The mental health program budgets total 51% of the budget and the developmental services budget totals 47% of the budget.



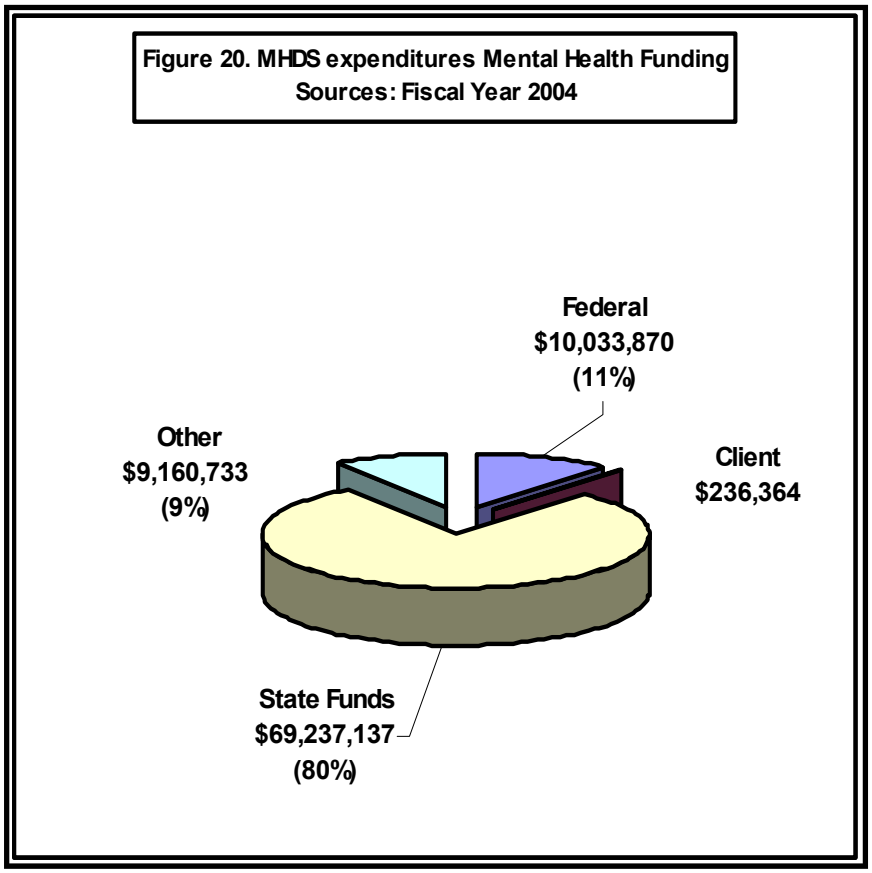


Fig. 19 and **Fig. 20** show funding sources and expenditures in Fiscal Year 2004 for Mental Health services.

Staffing to Meet Service Demands

Inpatient facilities are licensed and staffed to support a certain number of client beds. Other programs, such as service coordination have caseload standards or service level standards. When these are

exceeded, waiting lists occur.

The Division was budgeted for 1232 staff positions in fiscal year 2004. Of these, 812 people work for mental health agencies. **Figure 21** shows the distribution of staff in MHDS' mental health agencies. Sixty seven percent of these positions are employed in direct consumers care (see **Figure 22** sidebar). If all programs are combined, there is one direct care staff for every 43 mental health consumers. However, programs differ dramatically in the intensity of service and the staffing required to provide adequate service. The Lake's Crossing Center forensic facility has a ratio of one direct care staff for every 3 consumers. Inpatient facilities at SNAMHS and NNAMHS also have small consumer to staff ratios and serve consumers around the clock. Intensive outpatient services have reduced clinical caseloads, such as one clinician or service coordinator for every 15 consumers. Other intensive outpatient services take a team approach to help consumers reduce symptoms and develop self sufficiency. The ability to carry larger clinical or service coordinator caseloads increases as consumers become more independent and services focus more on life management needs than recovery from severe symptoms. Typically, service coordinator caseloads are one service coordinator for every 35 consumers. Many consumers are maintained and function in a stable fashion in the community, only returning for medical services. Thus, nurses providing medical oversight at the medication clinics carry larger caseloads of one nurse to every 217 clients.

Measuring Effectiveness and Performance Indicators in Mental Health Programs

The ability for state public mental health programs to monitor and assure the quality of services through consumer oriented outcomes has been driven from the Federal level through a Presidential Task Force and programs and funding through the Center for Mental Health Services. By participating in organizations such as the National Association of State Mental Health Program Directors, Nevada has shared in this national effort.

We have received funding from the Center for Mental Health Services through their Data Infrastructure Grant award. The purpose of this grant is to develop and sustain State and community data infrastructure that helps promote comprehensive, community based systems of care for all children and adults with mental illness or at risk of developing mental illness. National standardization of uniform data reporting for the States is a major goal of this grant.

These outcome areas have been further defined in Nevada through a stakeholder values clarification project. Value areas that have been addressed in the development of consumer oriented outcome measures include: Skilled Coping, Personhood, Symptom Reduction, Functioning, Community Integration, Involvement in Treatment, Satisfaction, Family Support and Safety. [5]

5 *Nevada Stakeholder's Priorities for Mental Health Outcomes*, McGuirk and Zahniser, 1996.

STAFFING RESOURCES

STAFFING PATTERNS

Figure 21 Staffing by Agency

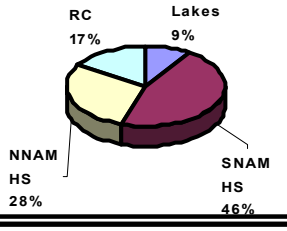
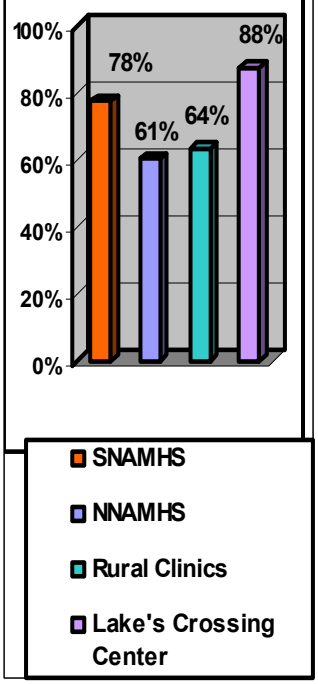
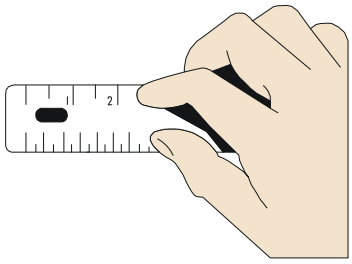


Figure 22. Percent of Staff That Provide Direct Client Care



MENTAL HEALTH INDICATORS



Performance indicators are instrumental in planning future services by helping predict program service demand

Our FY04 Quarterly Performance Indicator Report can be viewed on our website for those that want to look at data for FY04

Http://mhds.state.nv.us

New Mental Health Performance Indicators

The development of new performance measures in Fiscal Year 2002 has allowed MHDS to use more meaningful indicators of service in the Fiscal Year 2004-2005 budget. New annual budget indicators include:

Performance Indicators with definition:

INPATIENT

- Percent of clients in hospital over 90 days. - Current inpatients with length of stay (LOS) > 90 for those discharged.
- 30 Day Readmission Rate. - Rate of readmissions to an inpatient facility that occur within 30 days of a previous discharge from the same facility.

OUTPATIENT COUNSELING

- Wait Time. - Number of days from referral to first scheduled appointment.
- OC-Only Clients admitted to the POU - Percent of clients open only to OC who were admitted to the POU.

SENIOR MENTAL HEALTH OUTREACH

- Wait Time. - Number of days from referral to first scheduled appointment.
- Average Scale at Intake - The average score of clients using the Geriatric Depression Scale.
- Average Scale at 3 months -The average score of clients after 3 months using the Geriatric depression Scale.

SERVICE COORDINATION

- Inpatient Days Before and After Starting Program - Percent of time clients were in IP before and after starting to receive the program's services.
- Wait Time - Number of days from referral to first scheduled appointment.

INTENSIVE SERVICE COORDINATION

- Inpatient days Before and After Starting Program - Percent of time clients were in IP before and after starting to receive program's services.
- Re-offenses - Number of clients that are jailed because of a felony arrest while in the program.

MEDICATION CLINIC

- Clients Attending Their First Appointment - Percentage of new clients attending their first scheduled appointment.
- Average Wait Time - Average number of days from referral to first scheduled appointment.
- Wait Time - Number of days from referral to first scheduled appointment.
- MC-Only Clients Admitted to the POU - Percent of clients open to only MC who were admitted to POU.

MEDICATION CLINIC (MC) AND OUTPATIENT COUNSELING (OC)

- MC and OC only clients admitted to the POU - Percent of clients open only to MC and OC who were admitted to the POU.

GROUP HOUSING

- Inpatient Days Before and After Starting Program - Percent of time clients were in inpatient before and after starting to receive the program's services.

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SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program - Percent of time clients were in inpatient before and after starting to receive the program's services.

INTENSIVE SUPPORTIVE LIVING ARRANGEMENTS

- Inpatient Days Before and After Starting Program - Percent of time clients were in inpatient before and after starting to receive the program's services.

RESIDENTIAL TREATMENT PROGRAM

- Inpatient Days Before and After Starting Program - Percent of time clients were in inpatient before and after starting to receive the program's services.

PES (Psychological Emergency Services)

- Inpatient Deflections and Admissions - Percentage of persons receiving PES services who were deflected from IP versus those who were admitted to IP.

PACT (Program For Assertive Community Treatment)

- Inpatient Days Before and After Starting Program - Percent of time clients were in inpatient before and after starting to receive the program's services.

MENTAL HEALTH COURT

- Percent of time clients were in Inpatient before and after assignment to the Mental Health court. Also shows the time in the community.
- Percent of time clients were incarcerated before and after assignment to the Mental Health court.
- Percent of no-shows for Med Clinic for MH court clients as compared to overall no show rate for Med Clinic .

LAKES CROSSING CENTER

- Evaluation of Competency—Average length of stay. (Calculated from date of admission to date of discharge).
- Incompetent to stand trial - average length of evaluation. (Calculated from date of admission to date letter sent to court with findings).
- Competency Determination - Percent of clients admitted as incompetent to stand trial. (Calculated from date of admission to date letter sent to court with findings).

MENTAL HEALTH INDICATORS

Nevada's Mental Health Stakeholder Outcome Domains:

Symptom Reduction

Improved Functioning

Skilled Coping

Personhood

Consumer Involvement in Treatment Plan

Community Integration

Social Functioning

Safety

Quality of Life

MENTAL HEALTH ACCOMPLISHMENTS

The Division's Mental Health Disaster Preparedness and Response Program

The Division's Mental Health Disaster Preparedness and Response Program was formally established, with the hiring of a Statewide Disaster Response Coordinator and two Regional Disaster Response Coordinators. Over 190 disaster response / mental health crisis counselor volunteers have been recruited and trained to respond to both small and large scale disasters. Critical Incident Stress Management - trained volunteers provided a response during the Carson City Waterfall Fire to provide assistance to evacuees and support those who lost their homes in the fire. One of the goals of the program is to establish a system that provides for a graded range of acute psychosocial interventions and longer term mental health services to 5000 adult and pediatric clients and healthcare workers per 1 million population in the event of a large scale crisis or disaster.

FISCAL YEAR 03-04 ACCOMPLISHMENTS

MHDS STATEWIDE

MHDS GOAL OR OBJECTIVE
Develop And Implement Evidence Based Treatment And Interventions For Adults And Children.

- MHDS budget requests now seek funding only for programs that are evidence-based.
- MHDS has linked budget planning and legislative requests to a sequence of planning activities (e.g. Needs assessments, strategic plans) to ensure that efficacious programs are sustainable at the state level.
- MHDS increased efforts to work with national organizations and other states (e.g., EBP-Best Practice sites, JCAHO, etc.) for training consultation and support.
- MHDS continues to strengthen quality assurance/performance improvement and training efforts to achieve maximum adherence to standards and EBPS.

MHDS STRATEGIC OBJECTIVE
MHDS Will Ensure That The Vision, Mission, And Service Systems Meet The Expectations Of The Olmsted Decision In That Services And Programs Are Provided In The Most Normative Setting.

- 75% of Division budget has been utilized for community based services so that services that are more restrictive are available for people most in need of protective services (safety and symptom reduction).
- MHDS now builds budgets using an accurate (valid and reliable) methodology to determine caseload projections (CLEO).
- MHDS added additional Performance Improvement staff to focus on assuring client safety and quality services in Nevada's MH residential programs.
- MHDS hired a fulltime HIPAA officer who has begun a series of on site facility reviews and facilitating resolution of any HIPAA related concerns from clients, staff, or providers.
- MHDS funded a full time Clinical Program Planner position to coordinate adult mental health residential services state-wide for standardization of policy, procedures and performance improvement.

- MHDS has made improvements to the Pre-Admission Screening and Resident Review (PASRR) program by starting a PASRR Committee, which meets quarterly. The committee consists of staff from each of MHDS' six service agencies, Medicaid and First Health (Medicaid's PASRR contractor), and helps to provide oversight and direction to the statewide PASRR program. The goal of the PASRR program is to assure clients with mental illness and or mental retardation placed in nursing facilities receive specialized services to help facilitate and support their placement. An MHDS Quarterly Review form was developed to assist MHDS' agency PASRR coordinators when they conduct their quarterly visits in nursing facilities for their clients.

MHDS STRATEGIC OBJECTIVE:
MHDS Will Ensure That Services Are Consumer Driven In That Services Address The Interests, Rights, And Needs Of Each Individual Consumer.

- MHDS expanded the new Consumer Assistance Program, from the original six FTE in 1999, to 10 in 2004. New consumer assistant positions have been added in Winnemucca, and in the crisis unit at SNAMHS.

- MHDS augmented federal funds with state funds to ensure the continuity of care (from homelessness to support and/or independent living with the community of choice) for persons at risk (e.g. homeless, co-occurring disorders, other risky behaviors, etc.)

MHDS STRATEGIC OBJECTIVE:
MHDS Will Utilize Technology To Improve Accessibility To And Availability Of Services And The Efficient Use Of Resources.

- MHDS has completed Phase 1 of a three-year information system upgrade on schedule and under budget. Phase one resulted in a statewide-integrated patient management and billing system connected to 22 sites and a statewide-integrated pharmacy system for 4 pharmacies. All systems are linked electronically.

- MHDS has provided training to over 400 staff and users in using the new software (AVATAR) which will be used for statewide and national accountability.

MENTAL HEALTH ACCOMPLISHMENTS

The Division's Mental Health Disaster Preparedness and Response Program Overview:

Program was established to provide a statewide mental health crisis counseling response network. The Statewide Disaster Response Coordinator and two Regional Disaster Response Coordinators are working to meet the following goals:

Establish a system that provides for a graded range of acute psychosocial interventions and longer term mental health services to 5000 adult and pediatric clients and healthcare workers per 1 million population in the event of a large scale crisis or disaster

Recruit and train both State and private provider mental health responders

Develop Memorandums of Agreement with other State Agencies as part of the State Comprehensive Emergency Management Plan, MHDS Annex

Develop reciprocal disaster support systems and agreements with Nevada's bordering states

Work with both State and *Local Emergency Management agencies to develop a seamless response system*

Develop a media and public information campaign to provide information regarding "what to expect" in a large scale response

MENTAL HEALTH ACCOMPLISHMENTS

Mental Health Court Support Services

•MHDS requested funding to be able to provide residential support and intensive service coordination for clients in both Las Vegas and Reno to support Mental Health Court(s).

•Mental Health Court is a valuable addition to the array of services in Northern Nevada and will prove to be an increasingly effective method to prevent seriously mentally ill clients with criminal histories from re-offending and from being re-hospitalized

FISCAL YEAR 03-04 ACCOMPLISHMENTS (con't)

MHDS STRATEGIC OBJECTIVE:
UPDATE AND MAINTAIN A PLAN TO RESPOND TO EMERGENCIES AND DISASTERS I N NEVADA IN A TIMELY AND EFFECTIVE MANNER.

- MHDS is training approximately 190 persons statewide on mental health disaster response pertaining to critical incident stress management (CISM). The training focused on CISM interventions relative to peer support, individual and group crisis intervention, and terrorism/weapons of mass destruction.

- MHDS' statewide and regional (North and South) mental health disaster operational response plans are final and have been distributed. Training on how the plan would be activated and training of responders will continue on an on-going basis, as MHDS strives to put in place "surge capacity" to provide disaster mental health services during large scale disasters, particularly those of a bioterrorist nature.

OTHER 2003-2004 ACCOMPLISHMENTS:

- MHDS has maintained an annual statewide conference since 1999 for Personal Service Coordinators). The 2004 Conference occurred on Sept 21-23, and is the 5th annual conference. The 2004 conference focused on treatment of people dually diagnosed with mental illness and developmental disabilities. It was the most heavily attended conference we have had with approximately 300 in attendance.

- MHDS implemented (SB301) findings of the National New Freedom Commission; and began the Nevada MH Plan Implementation Committee. The Division Administrator has given testimony before US Congress on the Nevada Mental Health Plan Implementation Commission.

- We continued to improve the website we started a few years ago. We evaluated the effectiveness of this website and found it to be used by many thousands of people each month for many reasons. All our major publications and all policies are now available electronically.

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (SNAMHS)

- Clark County Health Department recently requested SNAMHS assume responsibility for Ryan White funding designed to provide

MENTAL HEALTH ACCOMPLISHMENTS

counseling services to seriously mentally ill clients infected with HIV/AIDS. This enabled SNAMHS to hire a psychotherapist to work specifically with this population at no cost to the general fund.

- The newly funded Mobile Crisis Team @ SNAMHS entered into a public private partnership with Montevista hospital. Each team maintains daily contact with the other and shares referrals with one another in an attempt to prevent duplication of services, i.e. the SNAMHS team refers those with insurance to the Monte Vista team while the Monte Vista team reciprocates with referrals for the uninsured and underinsured to the SNAMHS team thus maximizing the impact of the two teams for the community and emergency room.

- SNAMHS received financing to support 182 consumers from the last legislative session bringing the total number of consumers in residential support to over 600. Included in this number are 27 Intensive Supportive Living Arrangements (ISLAs) which provide 24 hour awake staff in a community setting for people with the most severe mental illness. Many of the people residing in the ISLAs spent years institutionalized. The first consumer placed into this program spent 12 years inpatient at SNAMHS. After 3 years in an ISLA he has never needed to be re-hospitalized. The ISLAs cost approximately half of what hospitalization costs and provides these individuals with the opportunity to interact and live in a community setting consistent with the Olmstead act.

- SNAMHS, in collaboration with the Eighth Judicial District Court, implemented the first Mental Health Court in Clark County using existing resources. The Eighth Judicial District Court has requested that SNAMHS encumber $150,000 from the Court to expand our services to this population of severely mentally ill individuals currently incarcerated in the detention centers in Clark County. Services will include case management, housing and medications.

- SNAMHS increased its Psychiatric Observation Unit capacity from 20 to 26 beds to assist in management of the increasing demand in the community.

- SNAMHS increased it Inpatient Hospital bed capacity to 77 beds in response to community needs and currently operates at its full licensed potential.

- SNAMHS has completed plans for the new 150 bed hospital and has submitted plans for Bureau of Licensure and Certification (BLC) approval.

- SNAMHS successfully deployed its CRISIS MANAGEMENT TEAM several times during the year including emergency

Highlight:

The opening in spring 2006 of a new state of the art, 150 bed Psychiatric Hospital in Las Vegas, NV, allows for treatment in a modern setting.

MENTAL HEALTH ACCOMPLISHMENTS

Data Excerpts from the NASMHPD Research Institute Report Latest funding study:

"Funding Sources and Expenditures of State Mental Health Agencies in Fiscal Year 2001":

MHDS spent 2% of their total expenditures on Administration in FY04 compared to the National average of 4.1%.

MHDS expenditures for Inpatient Services were 29% of the total expenditures compared to the national average of 39%.

management at the Grant Sawyer Building during the SARS epidemic as well as to the Salvation Army after a gas explosion.

- SNAMHS has taken a Leadership role in developing and implementing the Crisis Intervention team (CIT) training program for the Las Vegas Metropolitan Police and neighboring law enforcement agencies. SNAMHS has provided didactic and experiential training for over 140 police officers in Mental Health in Clark County during the past year.
- SNAMHS has instituted a second PACT TEAM, PACT TEAM II, (hospital without walls) which provides intensive Community Based Services to homeless citizens with severe mental illness.
- SNAMHS has increased the ability to bill Medicaid for services by reorganizing the Department of Psychology so that all persons admitted to the system either on an emergency walk in basis or through routine admission are evaluated clinically by a psychologist prior to referral which has increased eligibility for billed services.
- SNAMHS has leased space in the state building to a private provider who specializes in obtaining Medicaid /Medicare benefits for SNAMHS clients who have experienced difficulty in obtaining these benefits, thus maximizing the Federal share of the cost of services.
- SNAMHS has hired two Advanced Practice Psychiatric Nurses who are members of the medical staff and provide clinical psychiatric care under psychiatric supervision at less cost to the State.
- SNAMHS has employed a Physicians Assistant who provides medical care in the inpatient department at reduced cost to the State.
- SNAMHS was able for the first time in the Division, to be able to hire a psychiatrist utilizing the federal J1 Visa Program.
- SNAMHS' Consumer Service Assistants, employees who are also consumers of mental health services, conduct educational groups on the inpatient units and assess each patient utilizing a standardized consumer survey, prior to their discharge. This data is compiled by our Performance Improvement team and reviewed by SNAMHS leadership in our continuing attempt to improve the quality of our services.
- Each one of the four SNAMHS outpatient clinics has at least one bi-lingual staff member assigned and transfer requests are reviewed and approved based on the continued availability of Spanish speaking individuals at each site. SNAMHS also recently contracted for services through the Language Line which gives all SNAMHS staff members access to multi-lingual translators.
- SNAMHS was successful in hiring psychiatrists native from Thailand, the Philippines, Mexico, and Russia increasing the cultural competence of the Agency for the Hispanic, Pacific Rim, and Eastern European/Russian citizens served in

- The Psycho-Social Rehabilitation (PSR) program at SNAMHS prides itself on its ability to provide pre-vocational assistance and job placement. The Bureau of Vocational Rehabilitation is co-located at SNAMHS and PSR staff meet weekly with BVR staff to transfer clients ready for job training and placement. PSR at SNAMHS also works with the Ticket to Work Incentive and Investment Assistance program in assisting those with job readiness skills.

- Graduates from the Residency Program are a good ongoing source for psychiatric recruitment.

- All SNAMHS clients living in group homes receive 2 hours per day of training in Independent Living Skills in order to maximize self-sufficiency and to achieve the greatest level of independent functioning possible.

- SNAMHS received full accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for all of its programs including Community Services, Psychiatric Emergency Services and the Inpatient Hospital .

- SNAMHS successfully completed the transition from the AIMS Information Management System to AVATAR and the MEDIWARE Pharmacy System

SNAMHS has instituted monthly Town Hall Meetings as well as Employee of the Month, Employee of the Year, and an Employee (Staff) Recognition Luncheon.

- SNAMHS has become a training site for the new Psychiatric Residency Training Program in Las Vegas. In addition to obtaining increased service to clients.

- In addition to training medical students, nursing students, psychology and social work interns and most recently psychiatrists, SNAMHS has begun training pharmacy students from the Nevada School of Pharmacy. This is an expansion of an existing training program for pharmacy students from out of state.

- SNAMHS became a training site for Physician Assistants from Pennsylvania.

MENTAL HEALTH ACCOMPLISHMENTS

STRATEGIC PLANNING

The Division of MHDS strategic planning process began in 1995. The plan was again updated in 1997 and again in 2000. The 2000 Strategic Plan addressed national standards, service gaps, budget and program planning. Additionally, the division developed a legislative planning process to reflect a timeframe in which an MHDS Needs Assessment occurs every even-numbered year, with strategic planning reports made in alternating (odd) years. Therefore legislative planning could be linked with specific FY04/05 budget efforts to findings reported in the Needs Assessment and Strategic Planning.
The 2003 Strategic Plan and the upcoming 2004 Needs Assessment are being developed to assist MHDS through the FY06/07 biennium.

MENTAL HEALTH ACCOMPLISHMENTS

Accurate, Consistent Caseload Projections

- MHDS began using a standardized caseload projection technique, referred to as "CLEO" in 2002.
- This technique accurately projects massive caseload growth due to population increases in Nevada
- CLEO is used for both MH and DS programs.
- Generally, CLEO projections continue to show massive program needs over the next two years and beyond

More clinical office space in Carson City.

- During 2004, MHDS consolidate the Carson City MH and DS programs into a single administrative location for ease of public access
- New office spaces in Carson City increase the capacity for these clinics to serve the population needs of greater Carson City

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)

- In October 2003 NNAMHS initiated the fully funded support of the Washoe County Mental Health Court utilizing resources authorized by the 2003 Legislature. Prior to this, support for the court was on an ad hoc basis utilizing already existing resources. With the funding provided by the 2003 legislature NNAMHS contracted for service coordination with Project Restart and supplied residential support for mental health court clients. This partnership has grown and strengthened as the court has expanded its caseload. NNAMHS continues to contract with Restart but also provides service coordination through state staff for a significant number of court clients.

- NNAMHS has partnered with the Reno Police Department and Washoe County Sheriff to develop a Crisis Intervention team program. This program provides training for law enforcement officers in effective behavior management of people with mental illness and mental retardation. NNAMHS in conjunction with Sierra Regional Center, Lakes Crossing Center, Division of Child and Family Services, and the Reno Sparks Indian Colony will be providing training staff and allowing on site visits of trainees. The program has proved very successful nationwide, including Las Vegas, in reducing violent encounters between police and mentally ill people.

- As a result of the deterioration of many buildings, NNAMHS has adjusted and moved treatment programs in order to close unhealthy and unsafe buildings. This has resulted in better working conditions for staff and better environments for clients. It should also result in cost savings by reducing utility use. Buildings 9 and 24 have been closed this year. Plans are being made to close the other deteriorating buildings.

- In November 2004, NNAMHS closed its antiquated and inefficient laundry and began contracting for laundry services. This change will reduce cost of utilities and personnel. Although positions were eliminated, no staff were laid off. This is part of the continuing and larger effort to revamp operations to meet contemporary standards and increase efficiency.

- NNAMHS successfully completed the transition from the AIMS Information Management System to AVATAR and the MEDIWARE Pharmacy System.

- NNAMHS has become a training site for three local Schools of Nursing. Western Nevada Community College (WNCC), Truckee Meadows Community College (TMCC) and University of Nevada's (UNR) Orbis School of Nursing all rotate nursing students through the inpatient and outpatient programs.

Feedback from all schools indicate that this program is an enormous success and should prove to be a recruitment tool for psychiatric nurses in the future.

- In October 2003 NNAMHS implemented a Post doctoral psychology assistant program. This program is designed to hire newly graduated unlicensed psychologists and provide the necessary experience and supervision to enable these psychologists to achieve licensure. This expands NNAMHS role as a teaching facility and ensures a steady supply of new psychologists for the community

- NNAMHS has partnered with Sierra Regional Center to develop a program to better serve consumers who are both mentally ill and intellectually challenged. This program, called Cooperatively Serviced Individuals, has fostered better working relationships between mental health staff and developmental disability staff and has created a system which better serves those clients who require support from both agencies.

- NNAMHS initiated a consumer run drop-in center. This program provides a consumer operated program for clients and others to freely access and receive peer counseling, engage in leisure activities/outings and participate in group programs including snack preparation and other skill building exercises. This program is entirely operated by a Consumer Services Assistant with support from other NNAMHS staff.

- NNAMHS implemented an aggressive program to eliminate the use of seclusion and restraint in the hospital. This effort, which required retraining staff and a significant cultural change, resulted in a significant reduction in the use of seclusion and restraint. Recently inpatient staff has converted a seclusion room into a "comfort room". This room, which is furnished with comfortable furniture and other calming features can now be accessed by patients as a retreat to be used when they are stressed and need a place to calm down. NNAMHS will furnish a second such room in the near future.

RURAL CLINICS

- Rural Clinics nursing staff maintained an aggressive program designed to assist indigent and low income clients obtain medications. The success of this program is evidenced by obtaining medications valued at $600,000+, which is a significant savings for the general fund.

MENTAL HEALTH ACCOMPLISHMENTS

Homeless services – The Division of MHDS receives funding for programs specifically targeted for those people who are homeless and have a serious mental illness. They are:

PATH – Projects for Assistance in Transition from Homelessness –

The funding for 2004-2005 is $377,000 and the providers are: New Frontier Treatment Center in Fallon, ReStart in Reno, and The Salvation Army in Las Vegas Services that are provided with this money range from outreach to mental health services up to and including security deposits/rental assistance

Shelter Plus Care –

A grant from Housing and Urban Development (HUD) has provided approximately $4.5 million in tenant-based rental assistance funding to Division agencies since 1995. The grant is matched in aggregate by Division agencies with supportive services for those persons who are eligible (homeless and have a serious mental illness or other long-duration disability).

MENTAL HEALTH ACCOMPLISHMENTS

New Statewide Electronic Medical Records-

With funding provided last session, MHDS began a three-year project to put in place a statewide automate management information system. We have replaced the obsolete system with a state-of-the-art system including financial/pharmacy and electronic medical records.

MHDS' Specialized Services include, but are not limited to medications, psychotherapy, psychosocial rehabilitation, crisis intervention, day services, psychological services, advocacy and monitoring.

- The Bureau of Alcohol and Drug Abuse granted Rural Clinics $200,000 to provide service to approximately 100 clients with co-occurring disorders of mental illness and substance abuse.
- The empirical-based Lieberman and Boston models have been adopted and implemented in Rural Clinics psychosocial programs. All Clinic Directors, Service Coordinators and Nurses have been trained in using these approaches. Fidelity checks are being made to ensure the models are implemented appropriately.
- Empirically-based psychotherapy treatment (e.g., cognitive behavior for depression and anxiety disorders) is promoted in each clinic. Therapist "toolkits" that detail the procedures are available in each clinic.
- Rural Clinics has ushered in the first ongoing/routine mental health telecare project in rural Nevada. The medication clinic in one office is primarily served by computer and telephone-aided visual and verbal interactions between a psychiatrist in Reno and consumers at the distant Rural Clinic's office. Seventy-five clients in med clinic are served each month by this telecare project.
- Rural Clinics is collaborating with UNR Med School Rural Outreach Office to expand telecare services in rural Nevada, e.g., alcohol and substance abuse services for persons in Ely, Nevada.
- As a result of FY 04-05 budget increases:
  —Reduced wait list for med clinics
  —Added nursing service coordination and counseling staff
  —Added a sub-satellite office
  —Added administrative nurse to oversee rapidly growing nursing program.
- Improved work and treatment environment by moving two clinics to new offices (Pahrump and Carson Mental Health Centers) and by remodeling an existing office (Elko).
- Waterfall Fire emergency response was provided by several Rural Clinic staffs to aid the first responders and victims of the fire.
- Mobile crisis services 24 hours a day, 7 days a week in hospital and jails throughout rural Nevada.
- Integration of Behavioral Health Services at Carson Mental Health Center and Sierra Family Health Center.

- Converted MIS programs from AIMS to AVATAR

- Identified and corrected flawed methodology used to project external revenues. The error grossly overestimated external revenues and underestimated General Fund monies. The projected budget includes this correction.

- Recruitment in rural Nevada is an ongoing issue urban areas. Rural Clinics is taking initial steps to develop a career ladder by adding MH Technicians

LAKE'S CROSSING CENTER FOR THE MENTALLY DISORDERED OFFENDER (LCC)

- Lake's staff of forensic examiners has developed a curriculum and trained approximately 90 forensic examiners statewide to do competency evaluations. This training was done according to a revision in Nevada Statute 178 that occurred in the last legislature. Trainings will occur yearly to provide certification to new candidates and recertify existing examiners.

- Lake's has entirely updated the agency computer system and installed a server for a Local Access Network. This has greatly improved intra-agency communication and reduced the need for consumption of paper. All of the clinical staff now have internet access so that they can communicate Division wide and search the internet for state of the art health and psychiatric information to complete their reports. It also provides access to legal and court databases.

- Recruitment and hiring has been aggressive and LCC is nearly fully staffed. At the moment only three positions out of 76 remain vacant: 1 nurse, 1 administrative assistant and 1 forensic specialist 3.

- The Interlocal Agreement with Washoe County has been extremely active and we have expanded our provision of 70 outpatient evaluations in 1998 to 584 evaluations in fiscal year 2004. The agency has also provided some training per that agreement to the public defenders department.

- During the last Biennium LCC achieved complete POST certification for all the 43 forensics. Presently we have 40 certified and two awaiting to attend POST during the next training at the Department of Corrections. One forensic position is unfilled.

MENTAL HEALTH ACCOMPLISHMENTS

Residential Supports

Over the past two years MHDS markedly increased the number of people placed in the community. Our residential programs can provide group homes, supervised living arrangements, and apartments. These programs are used in Nevada to significantly reduce the severity of the homeless, indigent mentally ill, and individuals involved in our legal system.

Federal Law

Federal law requires any person needing admission into a nursing facility to first be screened to assure, if they have a mental illness, developmental disability or related condition, his or her mental health needs can be met.

As the state mental health and developmental services authority, MHDS is federally required to provide, or assure the provision of, specialized services to persons residing in nursing facilities with mental illness, mental retardation or related conditions.

MENTAL HEALTH ACCOMPLISHMENTS

MHDS Mental Health Prevalence in Nevada

The Nevada Division of Mental Health and Developmental Services contracted with the Western Interstate Commission on Higher Education (WICHE) to produce data on the prevalence of serious mental health issues in Nevada by county.

That prevalence data, which was based, in part, on 2000 census data, has been received and extrapolated to the year 2003 based on the most current Nevada demographic data. These data together with the reported number of clients served by MHDS agencies will be contained in a report that is currently being prepared and will be available on our web site.

http://mhds.state.nv.us/

On the following sidebar are thumbnail sketches of the most current estimates of the prevalence of mental health issues, the number served by MHDS, and the percentage of unmet need by county.

- Renovation of the facility is ongoing with three wings completely retiled and view glass installed in the thirty-six client doors on those wings. Architectural plans are in place to completely renovate the serving kitchen and resurface the multipurpose room floor with a safe and resilient floor-covering. A new security fence has been installed around the entire perimeter of the facility along with safety platforms on the air handler units. The staff has also been provided with special safety equipment to prevent injury for both clients and staff in crisis situations. A new highway patrol radio has been installed in the transport van to increase safety and security on transports, particularly across the state to Las Vegas. TV's have been housed in safety housings and infrared camera systems have been installed in several client rooms so the at risk clients can sleep at night while still being observed. The facility heightened its attention to maintaining an extremely safe environment for clients and staff.

- Programs for training psychiatric residents and psychology interns have been increased. The new director of the medical school psychiatry residency program will be providing service at the facility through a contract and assisting with consultation for licensure and accreditation.

- Efforts toward licensure and accreditation are ongoing and a time line has been initiated as well as funding requested for the process in the next budget. An informal review by the Bureau of Licensure and Certification has been completed in the last biennium and a number of the deficits corrected. Application is anticipated in November of 2005 after programs and renovation has been complete for six months.

- A number of new programs have been implemented including the following:

  1. The Activities Therapy Program has been entirely revamped and expanded. Five exercise bikes and two Bow-flex machines have been purchased along with mats, step aerobics platforms and exercise balls. Special groups are held daily utilizing this equipment as well as numerous activities in the gym including bowling, volleyball, basketball. Activities are designed individually as well as for groups and tournaments. This program also includes psychosocial rehabilitation groups conducted by the Activities Therapy staff with forensic specialists who have been trained to assist. A new garden group has also been initiated.
  2. All direct care staff have been scheduled to complete Dialectical Behavior Therapy training as part of the agency's initiative to reduce the use of seclusion and restraint. Approximately half of that training protocol was completed in

GOALS FROM THE MHDS STRATEGIC PLAN

- Develop and implement evidence-based treatment and interventions for adults and children.
- Ensure that the vision, mission, budgets and service systems meet the expectation of the Olmstead decision in that services and programs are provided in the most normative setting.
- Ensure that services are consumer– driven in that services address the interests, rights, and needs of each individual consumer (individual served).
- Utilize technology to improve accessibility to and availability of services and the efficient use of resources
- Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.
- Reduce the rate of suicide and other riskful behaviors in Nevada, which can cause injuries, death, etc.

SIGNIFICANT LEGISLATION AND OTHER ACTIONS

- In August 2002 a Suicide Resources Coordination Task Force (SRCTF) consisting of both public and private providers was formed. In 2003 they developed a "Nevada Suicide Prevention 2003 Resource Directory," which is available on the MHDS website.
- In October 2002 the Department of Human Resources, on behalf of the Nevada Task Force on Disability, published the *Strategic Plan for People With Disabilities,* intended to provide a review of Nevada's status and progress toward Olmstead compliance.
- In October 2002 the Division awarded $500,000 to WestCare Nevada, through funding by the Legislature, to implement a Homeless Outreach Pilot Evaluation (HOPE) project.
- By the end of the 2003 Legislative session the Division had received funding to ensure a new management information system that would be phased in over a two year period to assure accurate reporting for grants and automation of individualized mental health service plans and medical records.
- In August 2003 Senator Randolph Townsend initiated a series of meetings to establish a Nevada Mental Health Plan Implementation Commission responsible for implementing the recommendations of the President's New Freedom Commission of Mental Health.
- In December 2003, Clark County District Court will begin a mental health court for defendants with mental illness and charged with nonviolent felony offenses. The new program will divert suspects with mental illness into treatment. The court will begin with about 35 participants and will help with recidivism by helping them obtain suitable living arrangements, employment, appropriate counseling, job skills and management of their medications.

MENTAL HEALTH GOALS

(continued from left page sidebar)

County	Prevalence	Number Served	Percent Unmet Need
Carson	5,696	729	87.2
Churchill	2,553	297	88.4
Clark	164,176	14,497	91.2
Douglas	4,098	560	86.3
Elko	4,898	166	96.6
Esmeralda	109	0	100.0
Eureka	147	0	100.0
Humboldt	1,722	297	82.7
Lander	570	133	76.7
Lincoln	417	27	93.5
Lyon	4.250	1,005	76.4
Mineral	473	108	77.2
Nye	3,553	184	94.8
Pershing	867	69	92.0
Storey	343	0	100.0
Washoe	37,356	5,616	85.0
White Pine	969	71	92.7
Statewide	**232,557**	**23.759**	**89.8**

Lyon county has the lowest at 76.4%

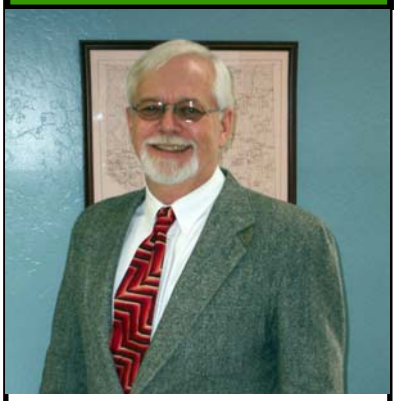
3 areas of concern are:
Esmeralda
Eureka
Storey

MH Challenge 2004-2006	*Plans for meeting the challenge*
Here Are Our Top 10 Challenges For The Next Two Years	
❶Address the overcrowding of emergency rooms in Southern Nevada	✶Complete new hospital in Southern Nevada ✶ Provide additional hospital beds using existing renovated facilities ✶Seek out even more inpatient beds ✶Expand PES in Southern Nevada
❷Suicide Prevention	✶MHDS continues to struggle to find stable and consistent funding to develop and then actually implement and evaluate a statewide mechanism which can address reducing the tragic occurrence of suicide in Nevada
❸National accreditation of all MHDS agencies	✶Obtain adequate staff infrastructure to 1) accredited all rural clinics and forensic programs, and 2) strengthen current programs at the larger urban programs in Las Vegas and Reno.
❹Performance Improvement	✶Expand quality assurance program and continue to monitor programs consumer oriented outcome measures.
❺Technology	✶Complete replacement of obsolete MIS system ✶Internet connectivity for all clinical and fiscal staff ✶MHDS Website updates and improvements ✶Videoconferencing
❻Maintain use of new antipsychotic medications	✶Invest in newer, state of the art medications that provide clients relief from mental health symptoms and reduce the demand for hospitalization
❼Use of proven clinical practices	✶All staff trained in using national "evidence- based practices", such as medication self management, PACT teams, family psycho education, supported employment, etc.
❽Improved services to clients in court or jail	✶Expand mental health courts ✶Assist NV correctional system in reorganization
❾Bioterrorism Preparedness	✶Develop adequate infrastructure and staff development to provide crisis counseling, critical incident debriefing, and related activities ✶Develop interstate linkages
❿Improved services to people who are homeless and mentally ill	✶Augment federal and state funds to provide continuity of care from a level of homelessness to a level of self sufficiency that is based upon the individual needs of each person

DEVELOPMENTAL SERVICES

Establish
partnerships
among stakeholders
as to the direction of
public mental health and
developmental services in the state.

FROM THE ASSOCIATE ADMINISTRATOR FOR DEVELOPMENTAL SERVICES



Dr Luke received his Ph.D. from Southern Illinois University. As Associate Administrator for Developmental Services, his efforts have focused on creating a regional based service system that provides person-centered and person-directed services. All three state run Regional Centers are accredited and currently more than 97% of the people served are supported to live in their communities.
Current goals are to increase self-direction through the use of a fiscal intermediary program and continue the reduction of institutional beds in favor of community-based choices.

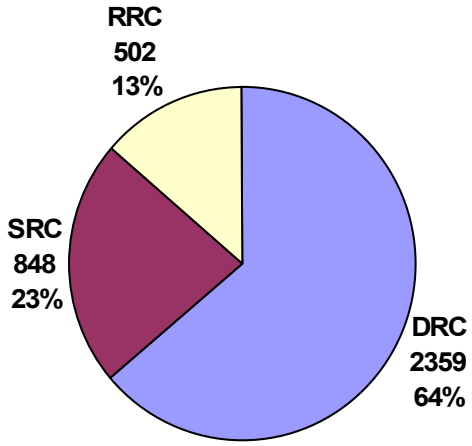
DEVELOPMENTAL SERVICES:
Involving Stakeholders

MISSION

It is the mission of each Regional Center to provide residential and community-based services for people in Nevada with developmental disabilities and related conditions. Agencies provide person-centered planning so that people can make choices about their lives, live in the least restrictive manner possible and live productively as part of the community.

Figure 25 shows the number of persons served by agency

Fig. 24 NUMBER AND PERCENT OF PEOPLE SERVED BY REGION FY2004



RRC—Rural Regional Center
SRC—Sierra Regional Center
DRC—Desert Regional Center

PERSON DIRECTED SYSTEM

The Regional Centers work in partnership with people who have developmental disabilities and their families to ensure they can select and direct meaningful services applicable to their principle goals, needs, and desires. Services are designed to maximize each person's independence, capabilities and satisfaction through a process referred to as person-directed planning.

Existing and available resources throughout the community are mobilized to ensure that support services are based on the value that all people with disabilities can and should decide for themselves what happens in their lives. The principles necessary to accomplish this begin with the person's desired future and focus on the person's abilities and capabilities.

DS is pursuing a Vision for the Year 2010

Background:

During 2004 the Division participated with a variety of interested groups and individuals, and persons to update and broaden service vision and goals consistent with the State Strategic Planning effort (AB513).

Process of Including Stakeholders:

People served, families, boards, advisory groups, and service providers participated in the strategic plan process as well as regional meetings.

Our long range service vision continues to emphasize community based services.

DEVELOPMENTAL SERVICES VISION FOR 2010

The Service Vision for 2010 includes seven areas of service and defines specific goals for each area. They are:

ACCESS:

- People will understand services available.
- People will receive the services they request through every Regional Center within a reasonable time.

SELF DIRECTION:

- People will direct their support plans.

PERSONS

Stakeholder Values

Choices:
People choose personal goals and services.
Choices include, but are not limited to, where to live and work and how to use free time.

People are Included in the Community:
People live and participate in the community interacting with other members and fulfilling different social roles.

Relationships:
People have friends and relationships and remain connected to their natural support networks.

Rights:
People exercise their full rights as citizens. If their rights are limited, they are afforded due process.

Dignity and Respect:
People are respected, have privacy, personal possessions, and choice about the sharing of personal information.

Health:
People have health care services adequate to achieve the best possible health.

Safety and Security:
People are safe, free from abuse and have economic

DS VISION

Service Accessibility

Service Coordination

Family Support

Jobs and Day Training

Residential Supports

Service Quality

RESIDENCE:

- People will live in non-institutional settings through out the local community.

FAMILIES:

- Children will live in a family setting.

COMMUNITY PARTICIPATION:

- People will have friends other than paid staff.
- People will meet their personal goals for employment, education, and retirement.

EMERGENCY AND SPECIALIZED SERVICES:

- People who need a crisis plan will have one in place.
- Regional Centers will have an emergency support system available.

HIGH QUALITY SERVICES:

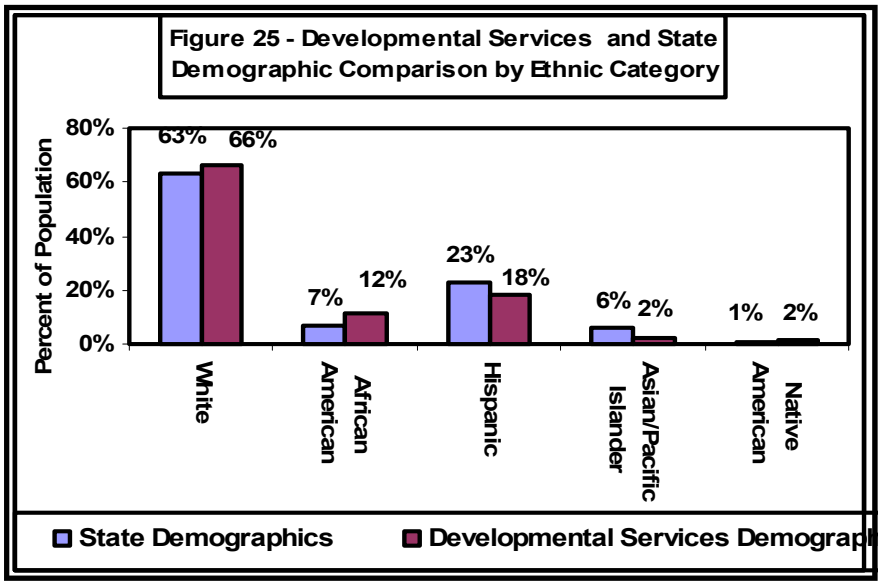
- Service Providers will participate in a data-based quality improvement process.

Who are the Recipients of Developmental Services

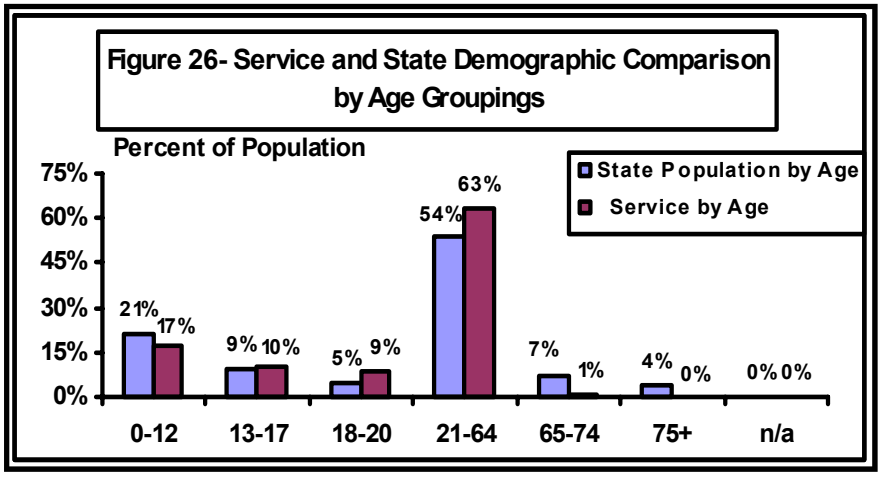
Developmental Services includes supports for children and adults with mental retardation and related conditions. Related conditions include persons with cerebral palsy, epilepsy/seizures, autism and other disorders. Of the total caseload of 3709, 68% were adults with mental retardation, 17% were children with mental retardation, 12% were children with related conditions and 5% were adults with related conditions.

Fifty seven percent (57%) of the recipients of Developmental Services are male and 42% female. The ethnic composition is 66% White, 12% Black, 18% Hispanic, 2% American Indian and 2% Asian/Pacific Islander. Nevada's ethnic population characteristics are compared to DS's persons served in **Figure 25.**

People receiving services consist of 29% children (aged 0-17) and 71% adults (aged 18+). Persons served are more likely to be in the age group from 21 to 64 years old (63%). The elderly comprise 1% of the service population (65+). **See Figure 26**.



Nevada's Demographics are Reflected in Persons Served



Children are the fastest growing portion of the caseload and now constitute 29% of the total caseload.

DS Mandate for Services

Nevada Legislative Intent

To charge the Division with recognizing its duty to act in the best interest of its clients by placing them in the least restrictive environment (NRS 433.003.2)

Federal Legislative Intent

"…to assure that individuals with developmental disabilities and their families have access to culturally competent services, supports, and other assistance and opportunities that promote independence productivity, and integration and inclusion into the community."

(The Developmental Disabilities Assistance and Bill of Rights Act Amendments of 2000)

DEVELOPMENTAL SERVICES' PROGRAMS

SERVICE COORDINATION

All people who are eligible for services from a regional center are assigned a service coordinator (case manager). Service coordinators assist people in obtaining needed benefits and assessments. Through person-directed planning, the service coordinator works directly with the person (and others), helping the person articulate his or her needs for the future. The service coordinator helps the person learn about and choose from available service providers and supports. Jointly, the person and service coordinator develop service plans that focus on achieving person - determined outcomes.

Service coordinators visit with the individuals at least quarterly to assess the efficacy of the plan and whether services are being provided as intended. Progress toward personal goals is assessed on an on-going basis. Plans may be updated and changed as the person's goals and needs for support change. At least annually, the service coordinator assesses the satisfaction of the person with the supports and services being received.

Service coordinators have a very important relationship with the person supported. They are responsible for overseeing the quality of services and for making sure that the person's plan of care and treatment is implemented and changed as needed. People are encouraged to choose their own service coordinator.

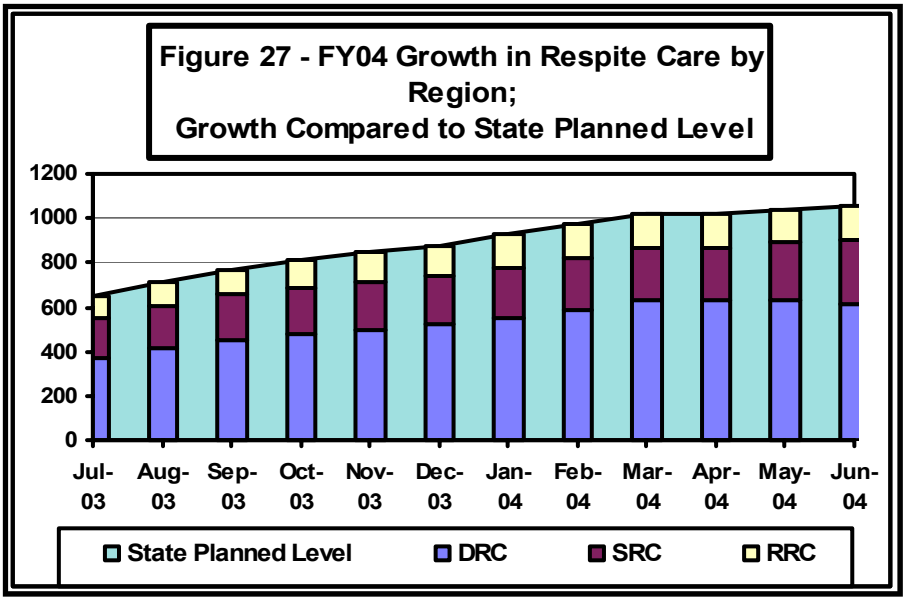
FAMILY SUPPORT SERVICES

The Family Support Program was developed to assist families of individuals with developmental disabilities and related conditions to care for their relatives in their family home. A variety of services can be combined as a family support arrangement. All individuals who are eligible for services through Desert Regional, Sierra Regional, and Rural Regional Centers and are living in their family home are eligible to apply for Family Support Services. The goal of the Family Support Program is to prevent costly out-of-home placement by assisting the family in caring for their relatives. Any charges for services are determined by using a sliding fee scale. Most individuals who are eligible for Medicaid pay no fees for services.

The Family Support Program provides the following services to individuals and their families:

1. Respite
2. Purchase of Service Vouchers
3. Clinical Assessments
4. In-Home Training Services
5. Counseling
6. Family Preservation Programs

Respite provides temporary care in or out of the family home. Respite gives families a break from the day-to-day responsibilities of caring for their loved ones. Families receive respite vouchers to use with providers of their choice. The amount of the voucher is based on individual's support needs and the available funding in the regional office. Families choose their respite



providers and select the days and times when they want to use their vouchers. The respite provider charges the family any co-pay (if one is due) and then bills the remaining cost to the regional center after providing the respite services. Families may use their yearly allotments all at once for a vacation or in small monthly increments. The choice is up to the family. **Figure 27** shows growth in this program exceeding planned levels in Fiscal Year 2004.

Purchase of Service Supplements (POS) are provided to families to assist them with the excess costs of services for their relatives. All alternative funding sources and existing resources must be used by the family before the POS is issued to them. Families who request a POS must meet financial guidelines to receive vouchers from the DS agency. The POS is available to eligible families one time per year, for a maximum purchase of $300. The family can use the voucher with any vendor or provider that accepts

Studies have consistently shown higher quality of life in community settings.

Family Support Programs assist families of individuals with developmental disabilities to care for their family member at home

DEVELOPMENTAL SERVICES & PROGRAMS

Clinical Assessments help the person's team develop training programs with the individual

Family Preservation provides monthly cash assistance to low-income families caring for relatives with severe or profound developmental disabilities

it. The service/goods are provided to the family and the State Agency is billed for the service. Examples of items that can be purchased with the voucher include such things as:

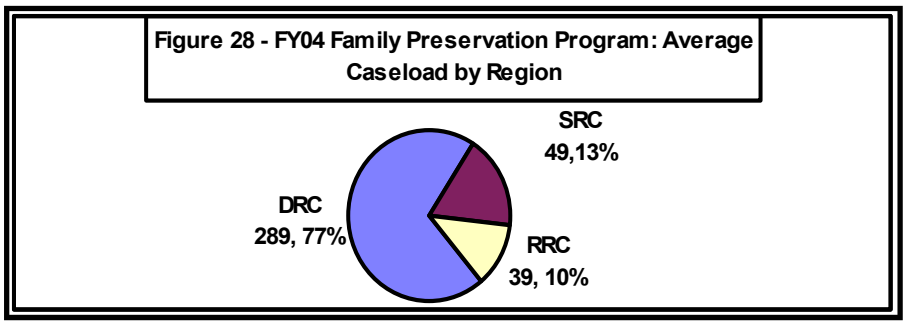
Medical/dental services not covered by insurance
Special diets, clothing, special equipment
Car seats, beds, special furnishings
Recreation, leisure needs, respite
Food, rent, utilities

Clinical Assessments are available for individuals who are in need of assessments or evaluations by a social worker, psychologist, or nurse. The assessments provide information that can be used to assist the individual's support team to develop training programs, and help the person gain services, obtain a job, move to a community residential program, etc. A sliding fee scale is used to determine if the individual is responsible for any costs. Medicaid and private insurance companies will be billed for the covered individuals who use the service. Families who are uninsured or who are unable to pay for the services will not be required to do so when funding is available through the DS agency.

In-Home Training is available to individuals and their families who request assistance to cope better with their relative's special needs. The in-home trainer can work with individuals and their families in such areas as personal care, meal preparation, safety and leisure skills, transportation, behavior management, etc. The family identifies the training needs with assistance from the service coordinator. Training can be provided on a short or long term basis depending on the person's needs and the availability of funding in the DS agency.

Counseling is available to individuals and their family members to provide support and guidance in problem solving. Many different areas of need can be addressed with counseling services including; personal independence, self-esteem, community participation, social-sexual issues, work issues, etc. The individual and/or the family can choose the counselor and most services can be billed to Medicaid or private insurance. A co-pay may be charged if the person is able to contribute to the cost.

The Family Preservation Program provides cash assistance to low-income families caring for their relatives with



severe or profound developmental disabilities in the family home. The financial assistance can be used for a variety of needed services (supplies, equipment, transportation, general income supplement). Payments are made to families with incomes less than 300% of poverty. **Figure 28** (previous page) shows program agency caseload percentages for this program.

Any individual or family member who wants to apply for Family Support Programs should contact their service coordinator (case manager) for more information or local DS agency to open a case for services.

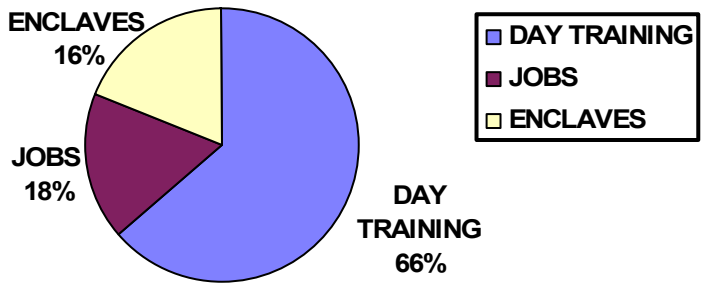
JOBS AND DAY TRAINING PROGRAMS

All adults who are eligible for services from a Regional Center are eligible for Jobs and Day Training Services. These services vary in the type and intensity of supports to allow individuals vocational choices. Supports range from pre-vocational and vocational training in supervised, structure settings, to enclaves (supervised work groups in community job setting), to supported employment, including activities needed to sustain paid competitive employment or (follow-along) services. Regional Centers contract with private, nonprofit organizations that operate Community Training Centers and with other qualified providers that offer training choices to individuals based on their interests and skill levels.

Job Services are available to individuals who need assistance to secure and maintain jobs in the community. Regional Centers contract with various private agencies as well as work cooperatively with the Bureau of Vocational Rehabilitation to provide work skill assessments, job development, job training, and follow-along services through job coaching.

Community Based Work Groups (ENCLAVES) provide individuals vocational opportunities in the community and the opportunity to acquire the necessary skills that will assist them in sustaining employment in the community. It enhances their

Fig. 29
EMPLOYMENT SETTINGS FY04



Job and Day Training Programs

Work is not only an important contribution to one's self esteem, but also links one to society

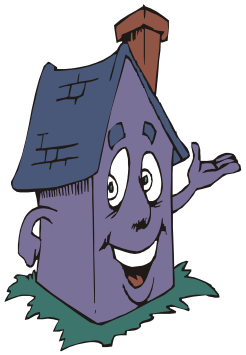
More than 45 community organizations host enclaves at their business settings providing individual integrated employment.

understanding of the community in which they live and the opportunities that are available to them. It also allows individuals to work outside of the facility-based environment (workshop) without being required to meet the industrial standards of the job. Under supervision of a staff member, people work at a job site in the community. The staff member is present to offer support and help should it be needed. Most enclaves are part-time. Currently, statewide enclaves are performing work at many local businesses/(food services, manufacturing, building and grounds, service industries and janitorial services).

Day Training Services are available through Community Training Centers (CTCs) and other qualified providers. Day training is designed to provide vocational experiences for people who need more intensive personal or behavioral supports or to assist individuals to learn skills necessary for success in a job.

Figure 29 (previous page**)** shows employment settings for the three programs.

Residential Supports provide alternatives to more expensive and restrictive institutional settings.



Choosing where, how, and with whom to live reflects one's personal power

RESIDENTIAL SUPPORTS

Residential Supports are available to people who require assistance and provide important alternatives to restrictive and costly institutional settings. All individuals who have open cases with a Regional Center may request residential supports. This program is designed with a goal of allowing people to live in a home of their choice as self-sufficiently as possible.

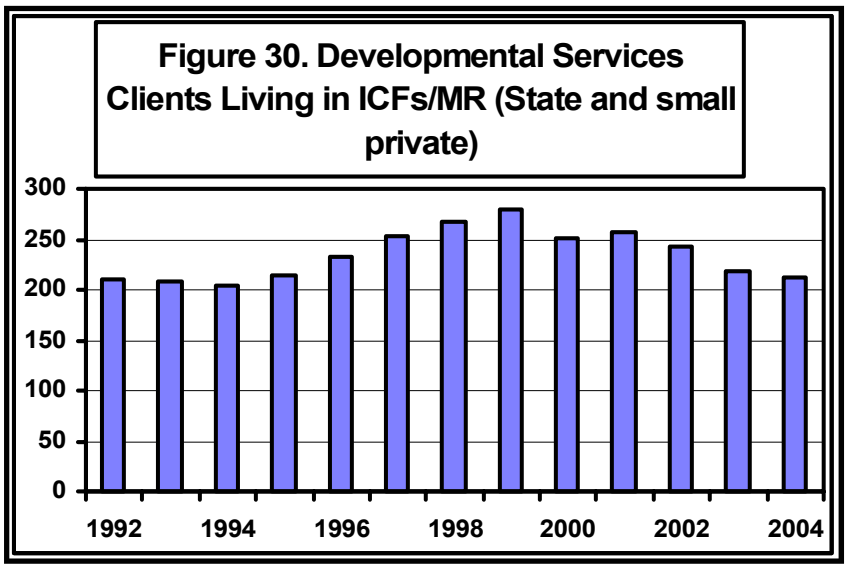
Residential services are funded by using the individual's own resources (Social Security benefits, job income, etc.) and supplementing these as needed with state and federal funds. The Nevada Medicaid Program funds the costs of many support services if the individual is eligible. The State also provides funds to assist the person with expenses of living in the community.

The following residential options are available:

1. Intermediate Care Facilities for people with mental retardation and related conditions. (ICFs/MR)
    a. State ICFs/MR
    b. Small Private ICFs/MR
2. Intensive Supported Living Arrangements
3. Supported Living Arrangements
4. Host Homes
5. Self-Directed Services using a Fiscal Intermediary (FI)

State ICFs/MR provide twenty-four hour supervision and training to individuals who require intensive support, medical care,

treatment, and training. Located at Desert Regional Center or Sierra Regional Center, these campus-based homes are licensed to provide services to approximately 100 people. The homes house from four to twelve people. Each home is staffed by state employees on a 24-



hour basis and must follow strict Federal and State guidelines. The programs are funded by Nevada Medicaid, and offer specialized services. This setting is also the most restrictive. **Figure 30** shows the number of people per year in all ICF homes.

Small Private ICFs/MR provide residential services in small community residences for up to six people. The individuals who require this level of care need intense treatment and training but live in community neighborhood houses with 24-hour awake supervision and support. The services are provided by private organizations (or the state) and are funded by the Medicaid Program. The same Federal and State guidelines also apply to these homes. The services provided in an ICF/MR Small are considered less restrictive than the ICF/MR services provided in large State run facilities because they are located in community neighborhoods.

Intensive Supported Living Arrangements (ISLAs) provide services in community residences for up to four individuals who live in their own home. The services are provided by private organizations. These services were developed as an alternative to an ICF/MR so that individuals could live in the community while receiving intensive support and training. Individuals who choose ISLAs must be capable of contributing to the costs of their services and may have intense medical or behavioral training/treatment needs. Twenty four hour supervision is provided .

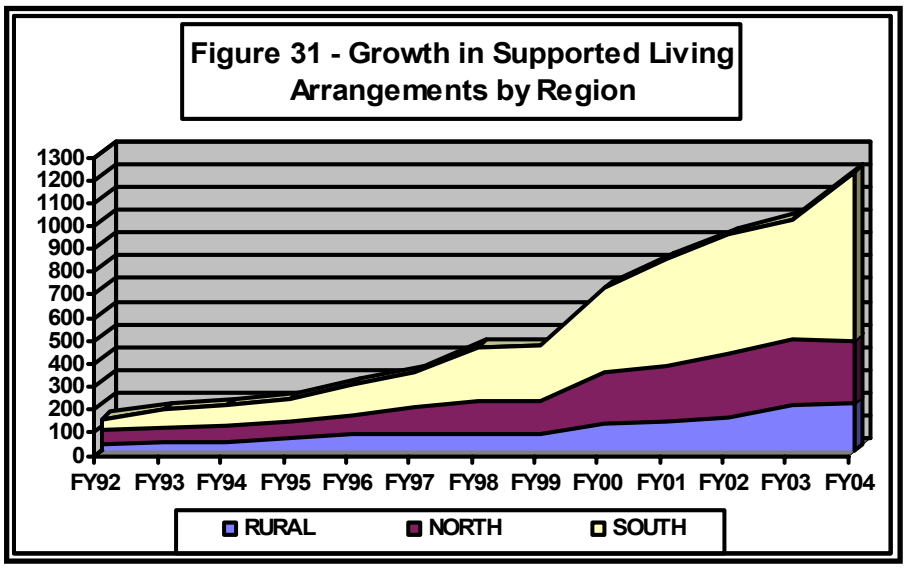
Supported Living Arrangements

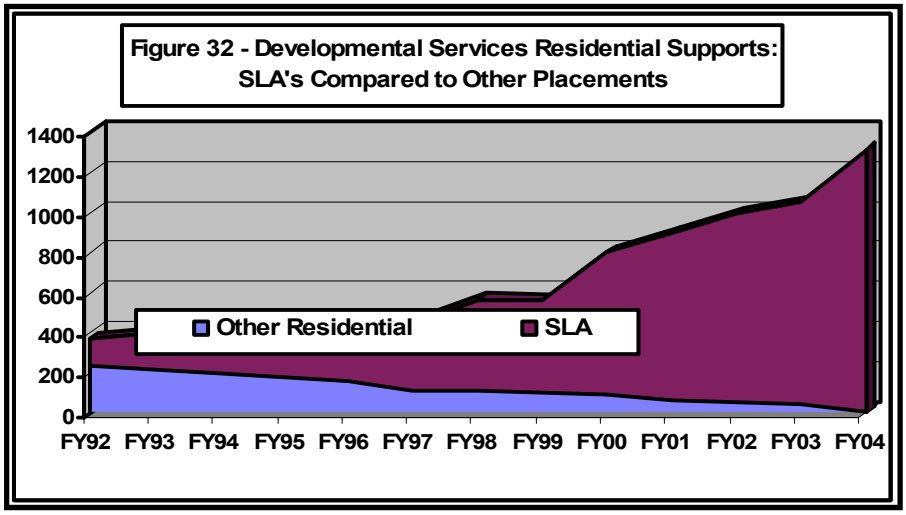
Individualized living supports supplement individuals' resources in their own homes, helping persons achieve independence in the community.

Supported living arrangements have allowed people to develop their own interests and skills

Growth in the SLA program reflects DS's goal of supporting individuals in the least restrictive environment possible

Supported Living Arrangements (SLAs) are individualized living supports that supplement individuals' resources in their own homes. Assistance is designed to help persons achieve and maintain maximum independence in the community. Supports are contracted with private providers. Support staff visit the person on an individualized schedule that depends on a person's needs and preferences. The services are paid for by the individual and may be subsidized by the State Agency and/or Nevada Medicaid. This can be one of the most self-determined level of support for individuals and is considered the least restrictive support option for adults. Because of this, SLAs are a preferred program (See **Figures 31 and 32**).





Host Homes are private homes in the community that typically support one individual who are usually younger or more dependent individuals who desire or need a more "family" type of

living situation. The providers are people who choose to have their homes licensed and/or certified to care for individuals with a developmental disability. The people who live in these homes are included in all the provider family's life and activities.

Self-directed services using a fiscal intermediary (FI) are supports that the family or person develop for themselves based on a budget. They hire their own staff with the assistance of a fiscal intermediary. The FI provides for the bookwork, tax reporting, and other accounting necessary to have employees. The family, person or their representative hire, train, and supervise the staff that provide services. This approach provides for maximum self-direction, flexibility and responsiveness to the person served.

Self direction means that people are more fully empowered to control their own lives.

Self-directed services can be provided through the use of an individual budget and fiscal intermediary agency. This allows people to employ their own staff.

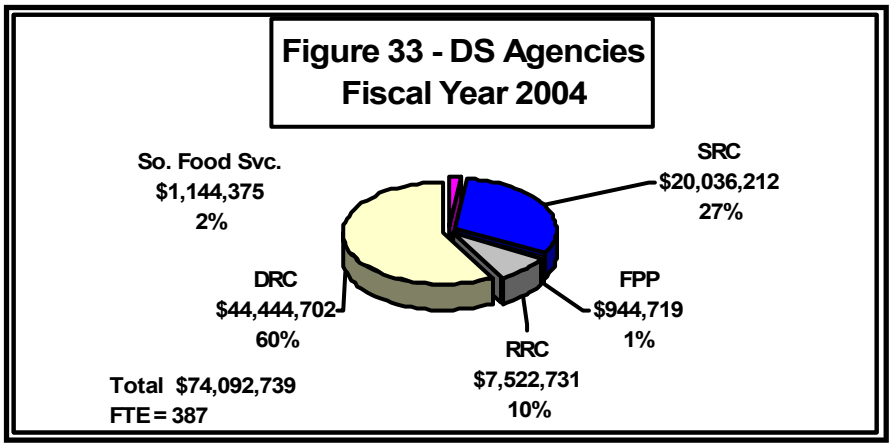
FUNDING & STAFFING

Waiting Lists are a key indicator of ability to meet public need for services.

DEVELOPMENTAL SERVICES FUNDING SOURCES AND EXPENDITURES

Funding for Developmental Services agencies for fiscal year 2004 was $74,092,739. The allocation of funding by DS agency is presented in **Figure 33**. This includes the allocation for the Family Preservation Program (FPP).

DRC= 44,444,702
SRC=$20,036,212
RRC=$7,522,731
FPP=$944,719
Food Service=$1,144,375
FTE (full time employee)=387



Revenue sources for Developmental Services are comprised of three main sources: State General Fund (54%), Federal (43%) and fees, charges and other sources (3%). Most of the federal funds represent the federal share of Medicaid (46% State share, 54% Federal share). Eligible Medicaid services are ICF/MR and community services through the Medicaid Home and Community-Based Services (HCBS) Waiver.

STAFFING TO MEET SERVICE DEMANDS

Background

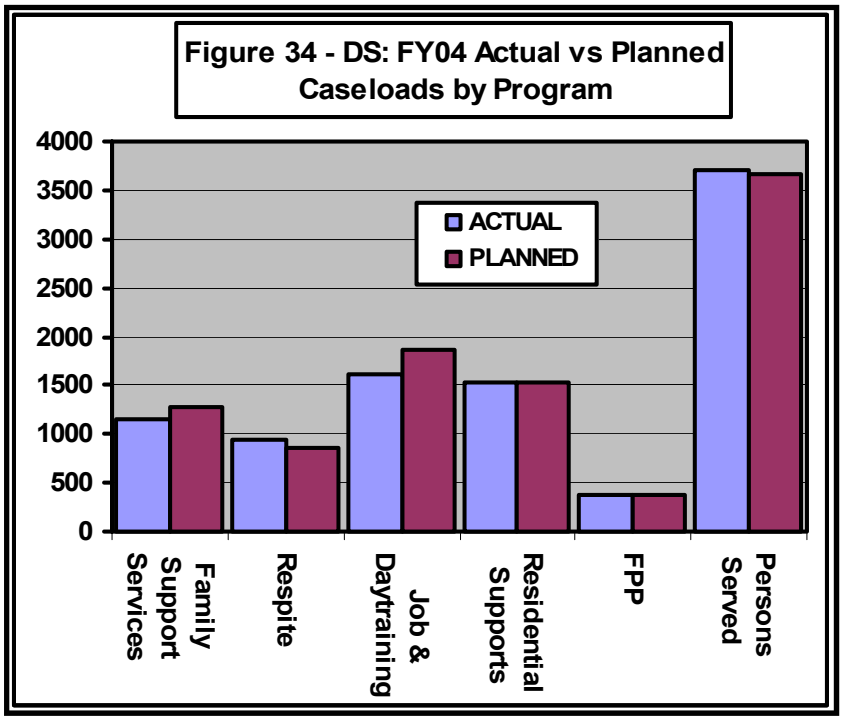
During recent sessions the legislature approved the administration plan to address current and projected waiting lists. The plan funded service growth evenly over the course of the biennium. The plan is intended to fund anticipated family and community based services such as family support, respite, service coordination, and jobs and day training such as provided through the Community Training Centers (CTCs). The plan also converted some state run ICF/MR placements to community living. The

Medicaid Home and Community Based Services Waiver (HCBS) provides federal match for most of the services.

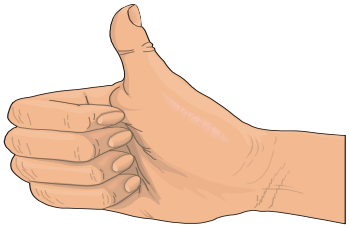
Caseload 2004:

Total Persons Served - The statewide waiting list increased from 88 in June FY02 to 163 in June FY04. During the same time the total statewide caseload grew from 3153 cases to 3709 cases. This was an increase of 556 cases or 18%. The length of time to open new cases is less than two months. There were 695 new applicants in FY03 and 867 new applicants in FY04.

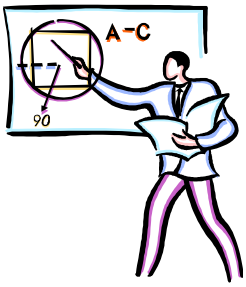
Jobs and Day Training – By June 2004 this caseload was 1615. There is no waiting list.



Residential Support Services - Residential waiting lists increased from 187 in June FY02 to 299 in June FY04 with an average waiting period of 7 months. This does not reflect the planned and funded growth the Division continues to phase in. There were 161 more funded support placements by the end of FY04. Waiting lists for community residential supports have increased despite the huge growth in new placements. The number of Supported Living Arrangements grew from 941 in June FY02 to 1316 in June of FY04. This is an increase of 375 new placements or a growth rate of 40%.



High demand exists for service coordination, family respite, and residential support



CASELOAD

PERSONAL OUTCOME MEASURES

AUTONOMY

People choose their daily routine.

People have time, space, and opportunity for privacy.

People decide when to share personal information

People use their environments.

HEALTH AND WELLNESS

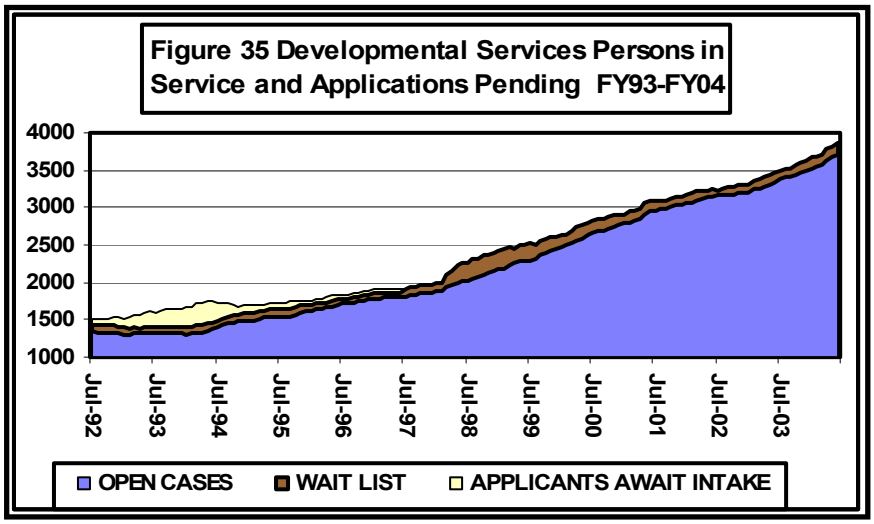
People have the best possible health.

People are free from abuse and neglect.

People experience continuity and security.

Of the total of residential supports in FY04 (1528) 103 persons or 7% were in state institutional services.

The nature of residential supports is changing in 200 cases, the family of a child is getting in-home residential supports through the



self-directed Fiscal Intermediary program. Much of the waiting list now reflects preference for the FI program. Many of the persons on the waiting list are requesting the FI program.

Respite - The respite program has not had a waiting list in the past, since all persons are enrolled and the available resources are spread amongst them. Families enrolled in the respite program have increased from 776 in June FY02 to 1056 in June of FY04. This growth of 280 families represents a 36% increase. There is no waiting list.

Family Preservation Program (FPP) - The Family Preservation Program, which covers persons with severe as well as profound developmental disabilities, increased from 347 recipients in June of FY02 to 387 in June of FY04. This was an increase of 40 families served or 12%.

Residential Outcomes - Agencies continue to progress at converting to community and individualized services. In June of FY04, 93% of all people receiving residential support lived in community settings of 6 or fewer individuals. This is a 4% increase from 89% in June of FY 02. In addition, 100% of persons in community living [Category 11] are receiving individualized service plans as driven by a Supported Living Arrangement contract. This is an increase of 5% from the 95% in FY 02. As of June FY 04 there were 200 fiscal intermediary contracts in place.

Summary

Developmental Services has grown considerably over the last ten years. The last two years were no exception. Overall, the Developmental Services caseload grew by 556 new cases or 18%. As of June FY04, the applicants pending represent 4% of the total persons served of 3709. High demand exists for service coordination, family supports, and residential supports.

The number of persons with related conditions has added over 273 new cases to the service delivery system in the last two years. Since June of FY01 the number of persons with related conditions (292) has more than doubled to 633 persons or 17% of the total persons served. By the end of FY04, persons with related conditions represented 37% of the new cases opened.

The number of children in the service population continues to grow. By June FY04 children were 29% of the total served. From FY02 to FY04 the number of children served increased by 251 to 1073 or a 30% increase. This will put more demand on Family Support Services. At this time children represent more than 50% of the new cases opened.

Service targets continue to be met. **Figure 34** (on page 59) shows attainment of planned levels in Fiscal Year 2004. **Figure 35,** previous page**,** displays the large growth in caseload over the last ten years. DS continues to phase in newly funded services. Growth will continue through FY05-FY07 period with well over 4200 persons expected to be served statewide. This population will include much more diversity in terms of children and adults served, their diagnosis, where they reside, and the services they receive.

MEASURING EFFECTIVENESSAND CONSUMER OUTCOMES IN DEVELOPMENTAL SERVICES PROGRAMS

Developmental Services collects a variety of information on customer outcomes and satisfaction. The measures are applicable at the personal, program, regional, and state levels. The information is used to track progress and identify areas for improvement.

Customer Based Outcomes and Satisfaction

Developmental Services uses the University of Nevada, Center for Excellence in Developmental Disabilities (UCED-Department of Education, UNR) to provide independent outcome and satisfaction surveys and interviews. The three Regional Centers contract with UNR to conduct various outcome assessments and projects. The thrust of the activities are to focus on services as seen by the recipient. UNR in collaboration with UNLV conducts these activities and provides customer perspectives from a variety of sources:

DS CONSUMER OUTCOMES

PERSONAL OUTCOME MEASURES

IDENTITY

People choose personal goals.

People choose where and with whom they live.

People choose where they work.

People have intimate relationships.

People are satisfied with services.

People are satisfied with their personal life situations.

RIGHTS

People exercise rights.

People are treated fairly.

DS CONSUMER OUTCOMES

Nevada continues to improve access to services and opportunities for community living.

Personal Outcome Interviews: Standardized interviews are conducted with a sample of persons using the same outcome tool that is used in the council accreditation process. The University trains and maintains certified interviewers through cooperative efforts with the Council. The findings and comments are provided to individual service coordinators as well as being used in program, regional and statewide reports. Summaries point to the need for additional ways that people can be socially integrated into community life. As a result, program development is being emphasized in that area. A Legislative report is provided prior to each session.

Focus Group Feedback: Additional information is derived from focus groups that target various subgroups of service recipients. During FY04, emphasis was placed on families with small children and their needs. A common theme was the need for improved access to information and education for the parents. Currently, focus group facilitators are meeting with parents of adult children. Results suggest the need for more support in long term planning to address times when the parents are no longer able to assist.

Self-Advocacy Group Input: With the help of the Regional Center funds and UCED staff, People First organizations are being supported in all three regions of the state. Recipient input is sought from these groups and the regional centers purchase consumer conducted interviews to obtain a customer perspective on services and support needs.

Community Inclusion as a performance indicator

Developmental Services tracks a number of indicators that express the speed of access to services and the level of community inclusion for persons served. Access is tracked by measuring the median number of days it takes for a person to have eligibility determined. This includes the application process and necessary background and assessments that must be accomplished. Community inclusion is also important for residential supports. It is monitored by knowing the number of people that are enrolled in the Medicaid Waiver. This Waiver provides for community based funding instead of institutional care. More generally, the percentage of community residential supports versus the percent of people in institutional care reflects an overall level of community inclusion.

To further understand the quality of community inclusion, the percentage of persons who have individualized supported living arrangements measures the degree to which people live in their own homes and have individualized support plans. Community support waiting time measures the level of access to community residential supports.

By having a small number of children in institutions, we

measure the ability of the system to keep children integrated, rather than institutionalized. By living in the community, children are exposed to the full range of experiences necessary for maximum development .

Maximum independence is an additional goal for persons with mental retardation and related conditions. While many people will not gain total independence, each person is supported to be as self sufficient as possible and to live as part of the community. The percentage of jobs and training in integrated employment settings portrays this. Inclusion provides expanded opportunities to participate in the community.

These system level measures are reported as performance indicators during the budgeting and legislative process. Care has been taken to coordinate with national databases that can be used to benchmark Nevada with other states.

Other Outcomes

The advent of the fiscal intermediary program provides a measure of self-direction. When individuals actually have a budget and direct their own services, they are more fully able to achieve personal outcomes. The number of individuals using the FI program offers a system level measurement of self-direction. It can also be used to determine what percent of individuals exercise this level of empowerment. Program reviews of providers by regional center staff provide a measure of the basic health and safety standards being met. This methodology is being developed with consultation from the Federal Center for Medicare and Medicaid Services (CMS) technical assistance project.

In addition to system outcomes described above, component programs such as service coordination (case management), family support, jobs and day training, and residential support have identified outcomes that track progress.

The outcome evaluation system in Developmental Services programs is designed to provide information that supports decision making at all levels, from policy to individual service decisions. The intent is to track information that reflects important service results for people served and provides a basis for decision-making that is in the best interest of stakeholders. In other words, the goal is to provide the best possible service to people with developmental disabilities and related conditions and the tax payers of Nevada. The findings from all methods help drive the activities of the quality improvement steering committees in the regions.

DS Consumer Outcomes

Greater availability of service through new eligibility definition.

Improved Access to Services.

Improving quality of service through the Accreditation Process.

Broadening and Strengthening of Programs.

Service Coordination addressing waiting lists.

Accomplishments in Developmental Services - FY 2004

GROWTH:

New Service Population Expands: People with Related Conditions

Since June 2000, the number of persons with related conditions has increased from 360 persons to 633 persons served (an increase of 75%). This service population currently represents **17%** of the total. This was the result of the expansion of the criteria for eligibility for Developmental Services to include conditions related to mental retardation, such as autism, cerebral palsy, epilepsy, etc. This has allowed persons with these developmental disabilities and their families to receive assistance form MHDS who previously had no access to needed services. Some **37%** of new cases opened in FY04 were persons with related conditions. This includes a substantial increase in services for autistic children. There were over 600 new cases opened in FY04.

General Caseload and CLEO (caseload evaluation organization) **Projections**

As of June 30, 2004 the DS caseload has increased 17.6% (to 3,709 from 3,153 since June FY02). Conservative projections for the future are: 3,976 in FY 05, 4,000 in FY 06 and 4,300 in FY 07. DS has instituted a regression methodology which projects future growth every six months based on the latest 36 months of actual caseload data. DS will continue to serve a larger percentage of children. They now represent 54% of all new cases opened, and 29% of total persons served in 2004.

Improved Access to Developmental Services

Expanded satellite offices within large metropolitan centers and in large rural regions, provide for better local access for service coordination. Within all regions the application process has been improved with additional intake staff that assist new applicants. In FY 04, the median number of days to accept and assess persons was 48 days statewide. DS in 2004 processed over 800 applications of which 600 became new cases.

Accreditation Process: All Regional Centers achieve Accreditation

Developmental Services continues to improve the quality of services. All three regional centers were accredited by *The Council on Quality and Leadership in Supports for People with Disabilities* in 2004. With 100% regional centers currently accredited, Nevada is one of the few states with a standard and uniform accreditation process in place. Also many provider agencies have been accredited or are utilizing the same evaluation criteria for quality improvement.

The University Center for Excellence in Developmental Disabilities (University of Nevada) provides feedback on the quality of services by independently interviewing persons served in regional services. The focus is on improving the quality of supports related to personal outcomes of persons receiving services.

NEVADA COMPLIED WTH THE OLMSTEAD DECISION:

Converted ICF/MR State run Programs to Community Living Options

The Olmstead decision says that all people with disabilities have the right to live in integrated community living settings. All people living in state-run ICF/MR institutions are evaluated by setting neutral assessments that identify the supports and services needed by the person to live successfully in a home in the community.

Developmental Services continues to convert state run institutional beds to provide community-based intensive supports .This offers persons the option to live in the community and be full citizens. Persons living in state run ICF/MR programs represent less than 3% of the total persons served in Developmental Services. Since 1999 when there were 168 beds, DS has transitioned 70 persons into the community. In 2004 there are only 103 persons in institutional settings.

Nevada also continues to return people from out-of-state institutions. In 2003 there were 19 persons living in other state facilities. By 2004, Nevada has reduced that number to 7 persons with 3 others to return in 2005.

Supported Living Arrangements (SLAs) Continue to Grow

The supported living arrangement program has grown over the last two years to provide personalized community living to 1,316 persons (2004) who would otherwise require more restrictive and costlier care. This represents a 40% increase in new (375 SLA's) since 2002 when there were 941.

The majority of persons receiving residential supports live in small-sized community settings. As of 2003, Nevada has the 6th highest percentage (80.3%) in the nation for people living in community residential settings of 1-3 occupants, (U. of Minnesota, Research & Training Center on Community Living, 2004).

Nevada has the 9th highest percentage (90.1%) in the nation for people living in community residential settings of 1-6 occupants, (U. of Minnesota, Research & Training Center on Community Living, 2004).

Nationally the estimated proportion of total MR/DD resources dedicated to community residences for 6 or fewer persons, related day programs, and individual support was 68%. Nevada ranked 23rd with 73% in 2002 (*The State of the States in Developmental Disabilities:2004.* AAMR page 23).

FAMILY SUPPORT:

Family Supports Broadened to Help People Remain in Their Natural Homes

Through family support programs some 2,182 persons can live and receive services in their own home. Developmental Services provides expanded family support services to over 1,000 families a month, This includes respite services as well as purchase of services, counseling, and screenings. In-home training and in-home supported living services divert people from waiting lists for out-of-home supports Direct financial assistance (the Family Preservation Program) has been expanded to cover additional families who care for a family member at home. The expansion (112 children) has been supported by the use of TANF funds. A total of 387 FPP families have been served in FY 04.

Jobs in the Community Promote Productivity and Integration

Developmental Services served over 1,600 persons in jobs and day training programs in FY 04. Some 529 persons were served through integrated employment programs. Of that total, 268 persons were working in enclaves (small work groups in community businesses). This employment option attracts people because of a higher average wage paid per hour than in non-private settings.

SELF ADVOCACY/SELF- DIRECTED SERVICES:

State DS services have expanded the way in which individuals and families can engage in self advocacy and self-directed services by providing support to the University (UCED) activities. People First organizations are being established in all three regions. In addition, the UCED program is piloting new models of self-directed services including microboards and consumer operated businesses.

DS has piloted and now adopted a self-directed fiscal intermediaries (FI) program that allows families to have an individual budget and hire their own support staff. Over 200 families in Nevada now participate in the FI program.

DS FY 2005-2007 CHALLENGES

INCREASED DEMAND FOR SERVICES

Nevada's growth continues be a challenge. Managing increased demand for services for people with Mental Retardation and Related Conditions will impact the service delivery system. Waiting lists for community residential services are a reality throughout the state. Payments and support for families are being reduced to accommodate increasing requests for family support services.

Plan for meeting the challenge:

- Budget for growth through analysis of service demands and needs assessment.
- Make more effective use of existing resources, reduce paperwork, and develop a more cost effective infrastructure to deliver and monitor services.
- Emphasize cost effective programs such as service coordination, family support, and community living. Maximize federal participation through the Medicaid HCBS Waiver and TANF funds to help defray service cost.
- Assist community provider efforts to obtain additional resources to maintain quality services.
- Fiscal Intermediary: expand this efficient and responsive means for people to choose and select the kinds of services they need.

PROVIDE FOR MORE COMMUNITY LIVING ALTERNATIVES

Persons who require intensive supports due to medical and/or behavioral needs continue to live in ICF/MR facilities, both in Nevada and out-of-state. All persons, regardless of their level of disability, should have the opportunity to be served either in their natural homes with sufficient assistance to the family, in therapeutic foster homes, or in other community living arrangements.

Plan for meeting the challenge:

- Assess and evaluate the intensive needs of persons living in institutional settings, and develop strategies that offer persons the choice to live in integrated environments.
- Increase available resources for Family Support Services and Family Preservation payments to families to re-unify and maintain families with persons who have intensive support needs.
- Work with providers to assist service users to identify and access community resources.
- Provide intensive community supports as institutional care decreases.

CONTINUE TO FOCUS ON PERSON- DRIVEN SERVICES, AND QUALITY IMPROVEMENT

Focus on efforts to discover, support and satisfy person-defined goals. Maintain on going quality improvement strategies for persons to attain personal outcomes with the best use of resources. Continue to plan and evaluate services based on feedback from service users.

Plan for meeting the Challenge:

- Develop ways for persons to better direct their own services. Listen and understand what services each person desires. Support their personal goals and evaluate their attainment.
- Develop standards for providers of service and require staff to meet the levels of quality assurance required in the HCBS Waiver.
- Maintain 100% accreditation through The Council on Quality and Leadership in Supports for People with Disabilities, a private organization that accredits organizations and agencies, which support persons with mental retardation.
- Budget for and support staff and provider training to improve quality assurance for people living in the community.
- Continue to work in partnership with providers and stakeholders to identify and increase the range and quality services based on service users' goals.
- Pilot micro boards to support living and work options.

Special Thanks To the Contributors

ACKNOWLEDGEMENTS

Production of a document of this kind involves the active participation of many individuals. The sum of their efforts is shown here. While the work of all of the people who contributed is greatly appreciated, a few individuals deserve special recognition.

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